

Lifetime Health Personal Health History

Name _____ Date _____

Address _____ City: _____

State: _____ Zip: _____ Occupation: _____

Phone (Home) _____ (Work) _____ (Cell) _____

DOB: _____ Age _____ Referral Source _____

Email: _____ # of Children: _____

Drug Allergies: _____ Other Allergies: _____

Birth Control (describe): _____

Current Meds and Vitamins: _____

Surgeries: (include dates): _____

Height: _____ Weight: _____ Last Blood Pressure Reading _____

Date of BP Reading _____ Current Treating Physician(s): _____

Family History:

- Heart Disease High Blood Pressure Stroke Cancer Glaucoma Diabetes
 Epilepsy Kidney Disease Thyroid Disease Mental Disorder Osteoporosis

Women Only

Menstrual Period Y ___ N ___ Age of onset _____ Cramps Y ___ N ___

Regular Y ___ N ___ Irregular Y ___ N ___ Date of Last Period: _____

Duration (days) _____

Moodiness/Depression with Menses Y ___ N ___ Last Pap Smear: _____

Trouble with arousal or desire Y ___ N ___

Vaginal Dryness Y ___ N ___ Last Mammogram: _____

Frequent vaginal infections Y ___ N ___

Losing urine w/ coughing or sneezing Y ___ N ___ Last Chest X-Ray: _____

Have you had a Hysterectomy? Y ___ N ___ Partial ___ Total ___ Date _____

Have you had an ablation? Y ___ N ___ Tubal Ligation? Y ___ N ___ Other? _____

Men Only

Prostate problems Y ___ N ___

Trouble Urinating Y ___ N ___

Decrease in size of urinating stream Y ___ N ___

Number of times urinating at night _____

Trouble with erectile dysfunction Y ___ N ___

Trouble with premature ejaculation Y ___ N ___

Decreased Sex Drive Y ___ N ___

Sleep: Difficulty falling asleep Y___ N___ Daytime drowsiness Y___ N___
 Snoring Y___ N___ Early morning awakening Y___ N___
 Wake Up Refreshed Y___ N___ Sleep Apnea Y___ N___

Habits

Smoke: Packs daily _____
 How long? _____
 Interested in stopping? ____

Coffee: Cups daily: _____
 Other caffeine: _____ Diet Sodas _____

Alcohol: Type: _____
 How many drinks _____ daily _____ weekly

Personal Medical History

- Headache Shortness of Breath Heart Palpitations Heart Murmur Chest Pain
- Dizziness/Fainting Problems with Circulation Allergies/Hay Fever Asthma
- Bronchitis Pneumonia Ulcer GI disorder Lactose intolerance
- Gallbladder disease Prostate disease Bowel Irregularity Incontinence
- Venereal disease Frequent infections Hepatitis Anemia Arthritis
- Osteoporosis Nervousness Joint Pain Depression Gout Scarlet Fever
- Chronic Fever Rheumatic Fever Mumps Measles Rubella
- Polio Diphtheria Tetanus Muscle aches

Pace Makers or Any Other Medical Devices: _____
Do you have sugar cravings? Y ___ N _____. **Carbohydrate Cravings?** Y ___ No _____
If yes, please describe: _____

Have you ever been treated for a mental disorder? Y __ No ____
If yes, please describe: _____

Have you ever taken Natural Hormones or Synthetic Hormones? Y ___ No _____
If yes, name the hormones and describe your experience with the hormones:

Have you ever been involved in a Weight Loss Program(s)? Y__ No ____
Have you ever taken weight loss medications? Y __ No __
If yes, please describe program/medications: _____

Primary Health Concern(s) /Objective(s): _____

Signature: _____

Date: _____

Print Name: _____

Weight Gain History (mark those that apply)

- **ONSET:** child __, teen __, adult __, perimenopausal __, other _____.
- **RATE:** rapid weight gain _____ or slow weight gain _____
- **INCITING FACTORS:** stress __, marriage __, divorce __, illness _____, accident __, medication _____, birth control _____, hysterectomy __, tubal __, ablation __, depo provera injection _____, other _____.

Describe any particular factor that you believe caused or contributed to your weight gain.

Previous Weight Loss Efforts

- **What have you tried in the past?**
- Commercial programs __, physician supervised __, self directed _____, “popular” diet _____, support groups _____, other _____

- **What has worked best for you?**

- _____
- What about it did you like and dislike?

- **What hasn't worked? Why not?**

Eating Patterns/Problems

- **Patterns:** Defined meals __ vs. grazing __, Time of day you eat _____
- **Triggers:** People __, places __, activities __ and feelings (stress, boredom, anger) __
Describe:

- **Eating Out:** Fast Food __ Dining Out ____ / How many times per week?

Problem Foods (describe what you eat)

- Starches

- Sugars

- Salty

- High Fat

Favorite Foods

- Anything you can't do without?

Exercise

- Historical benefit of exercise in your weight loss or weight maintenance (perceived value).

- Identify current physical activity level: What- how often – how long?

- Identify favorite exercise activity in past:

- Identify barriers to physical activity:

Diet Medication Usage

- RX (prescribed) and OTC (over the counter):

- Examples: Anorectics (Phen/Fen), Phentermine, Orlistat, Ephedra, Blockers, etc.

- What Worked:

- Problems or side effects:

Psych History

- Have you been diagnosed with an eating disorder?
 - Bulimia
 - Anorexia Nervosa
 - Night eating syndrome
- Many think they have an eating order but do not meet criteria for diagnosis..." Have you been diagnosed or prescribed by a healthcare professional"? Y ___ No ___

Family History

- Obesity
- Diabetes Type II
 - Impaired glucose tolerance _____
- Hypertension Y ___ No ___ If yes, are you on any blood pressure medications? Y ___ N ___
 - Cardio Vascular Disease
- Hyperlipidemia (high cholesterol)
- Thyroid Disease
 - Autoimmune disorders
- Psychiatric
 - Dysthymia, depression, ETOH

Social History

- Major life stresses (please describe any current stresses)
- "Readiness" and personal commitment for weight loss program (describe why you want to lose weight and why this is a good time)
- Major motivator(s) for weight management: (e.g. health, looks, major event coming up, etc.)