

Confidential Health History Questionnaire

Name: _____ Age: _____ Today's Date: _____
Family Physician: _____ Where located? _____
What is your reason for our visit today? Weight Management Fatigue Preventive Health Other

PRESENT STATUS:

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's care at the present time? Yes No

If yes, for what? _____

Are you taking any medications at the present time? Yes No

Med	Dosage	Med	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any Allergies To Medications? Yes No Please List: _____

Please List Allergies to Other Substances: _____

History of High Blood Pressure? Yes No

History of Diabetes? Yes No At what age diagnosed? ____

History of Heart Attack or Chest Pain? Yes No

History of Swelling Feet? Yes No

History of Frequent Headaches? Yes No Migraines? Yes No

History of Constipation (difficulty in bowel movements)? Yes No

History of Glaucoma? Yes No

SEXUAL AND REPRODUCTIVE HISTORY:

For Women Only:

MENSTRUATION:

Age Periods Began: ____ Cycle Length ____ days Period Length ____ days

Are Periods Regular? Yes No Pain Associated? Yes No Last check up ____/____/____

Hormone Replacement Therapy? Yes No Birth Control Pills/Patch/Shot? Yes No

Pregnancies: # ____ Miscarriages: ____ Abortions: ____ Living Children ____

HISTORY OF ANY SERIOUS INJURIES? Yes No

Specify: _____ Date: _____

Specify: _____ Date: _____

LIST ANY SURGERIES YOU HAVE HAD: (For example: Tonsils, Appendix, Dental, Gallbladder):

Surgery	Reason	Approximate Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY:

(check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Psychiatric Care/Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Breakdown | _____ |

FAMILY HISTORY:

	<u>Age</u>	<u>Health</u>	<u>Disease</u>	<u>Cause of Death</u>	<u>Overweight?</u>
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brothers:	_____	_____	_____	_____	_____
Sisters:	_____	_____	_____	_____	_____

- Has any blood relative ever had any of the following?
- | | |
|---|---|
| Arthritis: Yes No Who: _____ | High Blood Pressure: Yes No Who: _____ |
| Asthma; Yes No Who: _____ | Kidney Disease: Yes No Who: _____ |
| Cancer: Yes No Who: _____ | Migraine Headache: Yes No Who: _____ |
| Depression: Yes No Who: _____ | Obesity: Yes No Who: _____ |
| Diabetes: Yes No Who: _____ | Psychiatric Disorder: Yes No Who: _____ |
| Epilepsy: Yes No Who: _____ | Stroke: Yes No Who: _____ |
| Heart Attack, Angina: Yes No Who: _____ | Tuberculosis: Yes No Who: _____ |

HEALTH HABITS:

Smoking Habits: (answer only one)

- | | |
|--|---|
| <input type="checkbox"/> You have never smoked cigarettes, cigars or a pipe. | <input type="checkbox"/> You smoke 20 cigarettes per day (1 pack). |
| <input type="checkbox"/> You quit smoking ___ years ago and have not smoked since. | <input type="checkbox"/> You smoke 30 cigarettes per day (1-1/2 packs). |
| <input type="checkbox"/> You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke. | <input type="checkbox"/> You smoke 40 or more cigarettes per day (2 packs). |

Weekly alcohol intake: _____

of Sodas you consume per day: _____

OCCUPATION:

Would you describe your job as: Sedentary Mild Activity Moderate Activity Vigorous Activity
Check if your work exposes you to: Stress Heavy Lifting Hazardous Substances

NUTRITION EVALUATION:

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
In what time frame would you like to be at your desired weight? _____
Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
What is the main reason for your decision to lose weight? _____
When did you begin gaining excess weight? (Give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when? _____
Previous diets you have followed: _____
Give dates and results of your weight loss: _____

Is your spouse, fiancée or partner overweight? Yes No
By how much is he or she overweight? _____
How often do you eat out? _____
What restaurants do you frequent? _____
How often do you eat "fast foods?" _____
Who plans meals? _____ Cooks? _____ Shops? _____
Do you use a shopping list? Yes No
What time of day and on what day do you shop for groceries? _____
Food allergies: _____
Food dislikes: _____
Food you crave: _____
Any specific time of the day or month do you crave food? _____
Do you drink coffee or tea? Yes No How much daily? _____
Do you use a sugar substitute? Yes No Which? _____ Butter? ___ Margarine? _____
Do you awaken hungry during the night? Yes No
What do you do? _____
What are your worst food habits? _____
Snack Habits:
What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

Describe your usual energy level: _____

ACTIVITY LEVEL: (answer only one)

- Inactive—no regular physical activity with a sit-down job.
- Light activity—no organized physical activity during leisure time.
- Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
- Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

BEHAVIOR STYLE: (answer only one)

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make: _____

To the best of my knowledge, the above information is complete and correct. I understand that is it my responsibility to inform Dr. Patterson or her staff, if I or my minor child, ever have any changes in health.

Signature of Patient or Guardian

Printed Name of Patient or Guardian

____/____/____
Date