Weight Loss and Medical History Form

Please complete all 10 pages. To complete in PDF format , click on the top right of form in the "Fill and Sign" section. *Be sure to sign the last page electronically* and SAVE a copy for printing/sending. Send as an attachment in an email as the preferred method. (If you want to print a copy to complete manually, after you have completed the form and signed it, fax us a copy of the completed form at : (831)460-6422 or alternately, you may also scan the results and email BEFORE your first online visit to: asimplelowcarblife@comcast.net . This detailed information will assist us in providing you with the best nutritional consultation. Information provided is completely confidential and will never be shared with anyone other than our nutritional staff providing your care.

Date:_____ Name: _____

Age: _____ Date of Birth: _____

Sex: M ____ F ____

Current Health Status:

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

   Explain any "no" answer:

   _____

   _____

2. Are you under a doctor's care at the present time? Yes _____ No____

   If yes, for what? _____

   _____

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

Prescription Drugs (List all):

Prescription Drug:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all over-the-counter medications, vitamins, supplements:

Product:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Any allergies to any medications? Yes _____ No _____

   Please list: _____

5. History of High Blood Pressure? Yes _____ No _____

6. History of Diabetes? Yes _____ No _____

   At what age: _____

7. History of Heart Attack, Chest Pain, Shortness of breath, or other heart condition?

Yes _____ No _____

8. History of Swelling Feet? Yes _____ No _____

9. History of Frequent Headaches? Yes _____ No _____

Migraines? Yes _____ No _____

Medications for Headaches: _____

10. History of Constipation (difficulty having bowel movements)?

Yes _____ No _____

11. History of Glaucoma? Yes_____ No _____

12. History of Sleep Apnea? Yes _____ No _____

13. Gynecologic History:

Last menstrual period: _____

Any chance that you are pregnant? _____

Hormone Replacement Therapy: Yes _____ No _____

Birth Control Pills: Yes _____ No _____

Type of birth control pills : _____

Last Check Up, PAP smear, mammogram? _____
_____

14. Serious Injuries? _____

Specify (list all) : _____

15. Any Surgeries?

Specify: (List all): _____

_____

16. Past Medical History:

Diabetes _____ Gout _____ Kidney disease _____

High blood pressure _____ Thyroid disease _____

Depression _____ Bipolar disorder _____ Anxiety disorder _____

Bulimia _____ Anorexia _____

Cancer (when and what type) _____
_____

Other health problems (list) _____
_____
_____

17. Family history (list any positive responses and whom: father, mother, etc)

Diabetes? _____

Obesity? _____

High blood pressure? _____

Heart disease or strokes? _____

Nutrition Evaluation:

1. Weight (In morning first thing after urinating and nude) _____ pounds

   Height: _____ feet _____ inches Goal weight: _____ pounds

   (With measuring tape, measure the circumference of each of the following areas of your body, holding the end with one hand and circling around to meet the first end. Note the inches mark where they meet):

   Neck: _____ inches

   Chest (at nipple line): _____ inches

   Waist (at belly button): _____ inches

   Hips (at ball/socket joint): _____ inches

   Thighs (mid-thigh):

   Left thigh: _____ inches Right thigh: _____ inches

2. In what time frame would you like to be at your desired weight?
   _____
   _____

3. Birth Weight: _____Weight at 20 years of age: _____
   Weight one year ago: _____

4. What is the main reason for your decision to lose weight?
   _____
   _____

5. When did you begin gaining excess weight? (Give reasons, if known):
   _____

_____

6. What has been your maximum lifetime weight (non-pregnant) and when?

_____

7. Previous diets you have followed (Dates and results):

_____

_____

_____

8. Is your spouse, fiancee or partner overweight? Yes _____ No _____

9. By how much is he or she overweight? _____

10. How often do you eat out? _____

11. What restaurants do you frequent? _____

_____

_____

12. How often do you eat “fast foods?” _____

13. Who plans meals? _____ Cooks?_____

Shops? _____

14. Do you use a shopping list? Yes _____ No _____

15. Food allergies: _____

16. Food dislikes: _____

17. Food(s) you crave: _____

18. Any specific time of the day (or month) that you crave food?

_____

19. Do you drink coffee or tea? Yes _____ No _____

    How much daily? _____

20. Do you drink cola drinks? Yes _____ No _____

    How much daily? _____

21. Do you drink alcohol? Yes _____ No _____

    What type? _____How much daily? _____

    Weekly? _____

22. Do you use a sugar substitute? What kind? _____

    Butter? _____ Margarine? _____

23. Do you awaken hungry during the night? Yes _____ No _____

    What do you do when hungry at night? _____
    _____

24. What are your worst food habits? _____
    _____

25. Snack Habits:

    What do you snack on? _____

    How much? _____ When? _____

26. When you are under a stressful situation at work or family related, do

    you tend to eat more? Explain: _____
    _____

27. Are currently undergoing a stressful situation or an emotional upset?
    Explain: _____

28. Smoking and other Habits:

    I have never smoked cigarettes, cigars, or a pipe. _____

    I quit smoking years ago and have not smoked since. _____

    I quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling. _____

    I smoke 20 cigarettes per day (1 pack). _____

    I smoke 30 cigarettes per day (1-1/2 packs). _____

    I smoke 40 cigarettes per day or more (>2 packs). _____

    I have a history of substance abuse _____
    (If yes, what drugs were/are used) _____

    _____

    (This information is only used to assist you to overcome any obstacles that you may be facing that may interfere with weight loss.)

29. Typical Breakfast, time eaten, where, and with whom:

    _____

    Typical Lunch, time eaten, where, and with whom:

    _____

    Typical Dinner, time eaten, where, and with whom:

    _____

30. Describe your usual energy level: _____
_____

31. Activity Level (answer only one):

Inactive _____
Light activity _____
Moderate activity _____
Heavy activity _____
Vigorous activity _____

32. Behavior style (answer only one):

I am always calm and easygoing. _____
I am usually calm and easygoing. _____
I am sometimes calm with frequent impatience. _____
I am seldom calm and persistently seeking advancement. _____
I am never calm and have overwhelming ambition. _____
I am hard-driving and can never relax. _____

33. Please describe your general health goals and desires: _____
_____
_____

Thank you for completing this form. This information will assist us to more accurately assess your specific problem areas.

If you have any medical problems for which you are taking medications, you will need to obtain specific permission from your doctor or healthcare provider to participate in our weight management program. You agree that this is your sole responsibility. You further agree to have your personal physician or healthcare provider adjust or otherwise manage any prescribed medications that may be affected by weight loss. (Sign next page).

ATTESTATION:

I hereby attest that these statements are truthful and accurate to the best of my knowledge; that I am 18 years of age or older; and that I am not pregnant or breastfeeding. I also agree that it is my sole responsibility to obtain permission from my physician or heathcare provider to participate in this program (if I have indicated that I have any medical problems that require prescription medications or if I have indicated that I am not in good health). If I am on medications for any reason, I realize that weight loss can affect the dosage requirements and that I will contact my physician or healthcare provider for any medication adjustments. I understand that this weight management program offers nutritional guidance and coaching only and that no medical management or medical relationship is offered or provided to me. I understand that medical advice can only be provided by a licensed healthcare provider who has interviewed and examined me, and documented the encounter.

_____ _____

Signature Date

_____

Print Name