**Fat Loss Program Medical History Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female**

**Address :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State :\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family/Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History :** Check all that apply and add any pertinent information:

\_\_\_\_ Diabetes Mellitus, Last Hgb A1C \_\_\_\_\_ \_\_\_\_ Hypertension

\_\_\_\_ Elevated Cholesterol \_\_\_\_ Heart Condition

\_\_\_\_ Coronary Artery Disease \_\_\_\_ Congestive Heart Failure

\_\_\_\_ Arrhythmia \_\_\_\_ Valvular Heart Disease

\_\_\_\_ Myocardial Infarction \_\_\_\_ Stroke or other neurological condition

\_\_\_\_ Gallbladder Disease or Gallstones \_\_\_\_ Liver Disease

\_\_\_\_ Peptic Ulcer Disease \_\_\_\_ Kidney Disease

\_\_\_\_ Thyroid Disease \_\_\_\_ Asthma

\_\_\_\_ Emphysema \_\_\_\_ Chronic Bronchitis

\_\_\_\_ Blood Clots \_\_\_\_ Cancer

\_\_\_\_ Anxiety \_\_\_\_ Depression

\_\_\_\_ Other Psychiatric Disorder \_\_\_\_ Bone Fracture in the last 6 months

\_\_\_\_ Pregnant or intend to become pregnant in the near future

\_\_\_\_ Breastfeeding \_\_\_\_ Other Medical Condition: \_\_\_\_\_\_\_\_\_\_

**Surgical History:** List all prior surgeries and dates. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** Please list all prescription or over-the-counter medication or food allergies and reactions that you have had to these products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications :**Please list all prescriptions and over-the-counter medications and doses:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Children \_\_\_\_\_\_\_\_, Tobacco Use \_\_\_\_\_\_\_\_\_\_

Alcohol Use \_\_\_\_\_\_\_\_\_\_\_\_, Illicit/Recreational Drug Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Information strictly confidential)

**Family History:** Please note any medical problems and degree of obesity.

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet & Exercise History :** Please list any diet programs used in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription or over-the-counter diet medications used in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_