OBESITY HISTORY

NAME: _____

PHYSICIANS NAME: _____

REFERRED BY: _____

ACTUAL WEIGHT: _____ HEIGHT:_____

WHAT HAS BEEN YOUR MAXIMUM WEIGHT: _____

APPROXIMATE AGE YOUR OBESITY BEGAN: _____

WHICH TREATMENT YOU HAVE TRIED WAS MOST SUCCESSFUL?

WHAT DO YOU FEEL IS YOUR IDEAL WIGHT? _____

HAVE YOU READ THE BOOKLET?_____

HAVE YOU BEEN TO ANY MEETINGS? _____

ARE YOU EMPLOYED? _____

OCCUPATION? _____

HISTORY OF MEDICAL TREATMENT FOR OBESITY

PLEASE LIST MEDICAL TREATMENT FOR YOUR OBESITY BY PHYSICIANS, CLINICS ETC. (Include complete names and places)

LIST OTHER DIETS YOU HAVE BEEN ON

LIST EXERCISE PROGRAMS YOU HAVE ATTENDED

MEDICATIONS: PHEN FEN ( ) REDUX ( )

LIST OTHERS: _____

HAVE YOU HAD ANY PREVIOUS SURGICAL TREATMENT FOR OBESITY?
YES ( ) NO ( ) IF YES PLEASE DESCRIBE

DO YOU EAT BREAKFAST? YES ( ) NO ( )

DO YOU EAT LUNCH? YES ( ) NO ( )

DO YOU EAT DINNER? YES ( ) NO ( )

DO YOU GRAZE (snack a lot) DURING THE DAY? YES ( ) NO ( )

SIZE OF MEALS: LARGE ( ) SMALL ( ) NORMAL ( )

DO YOU EAT RED MEAT ? YES ( ) NO ( )
(Indicate times per week) _____

DO YOU EAT SWEETS? YES ( ) NO ( )
(Indicate times per week) _____

DO YOU EXERCISE PRESENTLY? YES ( ) NO ( )
(Indicate times per week) _____

LIST TYPE OF EXERCISE _____

DO YOU SMOKE? YES ( ) NO ( )
IF SO HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES( ) NO ( )
IF SO HOW MUCH? _____

DO YOU TAKE DRUGS? YES ( ) NO ( )
IF SO WHAT TYPE? _____
HOW OFTEN?_____

HAVE YOU HAD ANT PROBLEMS WITH ALCOHOL OR DRUG ABUSE?
YES ( ) NO ( )

HAVE YOU EVER HAD PSYCHOLOGICALOR PSYCHIATRIC TREATMENT?
YES ( ) NO ( )
WHEN?_____

GYNECOLOGICAL HISTORY

DATE OF LAST PHYSICAL: _____

RESULTS OF PAP SMEAR: _____

DATE OF LAST MAMMOGRAM: _____

RESULTS OF MAMMOGRAM: _____

IF YOU HAVE BEEN PREGNANT – list number of pregnancies and any complication

DO YOU HAVE ANY OTHER GYNECOLOGICAL PROBLEMS?

MEDICAL HISTORY

PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

Pulmonary problems (respiratory)
____ pneumonia
____ sleep apnea
____ asthma
____ other explain _____

Cardiac problems
____ chest pain
____ coronary artery disease
____ hypertension
____ other explain _____

____ diabetes
____ joint pain
____ lower back pain
____ kidney disease ____ stones
____ pancreatitis
____ gall bladder disease ____ stones
____ liver disease ____ hepatitis ____ jaundice
____ stomach ulcers
____ heartburn
____ hiatal hernia
____ colitis
____ diarrhea how many bowel movements per day ____
____ leakage of urine
____ thrombophlebitis (blood clots in legs)
____ thyroid disease
____ glaucoma
____ neurological disorders
____ seizures
____ rash under skin folds
____ depression

LIST ALL YOUR PREVIOUS SURGICAL PROCEDURES – INCLUDE DATES

LIST ALL CURRENT MEDICATIONS: INCLUDE DOSAGES

LIST ALL ALLERGIES TO MEDICATION AND FOOD

HISTORY OF DISEASES WITHIN YOUR FAMILY
(indicate which family member is afflicted with the disease)

Hypertension _____
Diabetes _____
Stroke _____
Cancer – indicate type _____
Other diseases explain _____

HISTORY OF OBESITY WITHIN YOUR FAMILY

(indicate which family member is or has been obese)

MATERNAL	**PATRERNAL**
GRANDMOTHER ( )	GRANDMOTHER ( )
GRANDFATHER ( )	GRANDFATHER ( )
MOTHER ( )	FATHER ( )

SISTERS ( ) how many obese? _____

BROTHERS ( ) how many are obese? _____

YOUR CHILDREN

DAUGHTERS ( ) how many are obese? _____

SONS ( ) how many are obese? _____