MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Sex: M F

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. History of High Blood Pressure? Yes No
3. History of Cardiovascular Disease? Yes No
4. History of Diabetes? Yes No
5. History of Thyroid Disease? Yes No
6. History of Hyperlipidemia? Yes No
7. History of Heart Attack or Chest Pain? Yes No
8. History of Frequent Headaches? Yes No
9. History of Constipation? Yes No
10. History of Glaucoma? Yes No
11. History of Drug Abuse? Yes No
12. Previous Bariatric Surgery? Yes No
13. Are you a Smoker? If so, how many per day? _____ Yes No
14. Do you drink Alcohol? If so, how many drinks per week?_____ Yes No
15. Are you under a doctor's care? Yes No
    If yes, state reason: _____
16. Are you taking any medications at the present time? Yes No
    What: _____ Dosages: _____
    What: _____ Dosages: _____
    What: _____ Dosages: _____
17. In the past 14 days have you taken any of the following medications (Circle all that apply):
    a. Tranylcypromine (Parnate) b. Isocarboxazid (Marplan)
    c. Phenelzine (Nardil) d. Selegiline (Emsam, Eldepryl, Zelapar)
18. Any known allergies? ...Medications?
    If yes, list: _____
19. Family History:
    a. Glaucoma: No Yes, Who:_____
    b. Asthma: No Yes, Who:_____
    c. Epilepsy: No Yes, Who:_____
    d. High Blood Pressure: No Yes, Who:_____
    e. Kidney Disease: No Yes, Who:_____
    f. Diabetes: No Yes, Who:_____
    g. Tuberculosis: No Yes, Who:_____
    h. Psychiatric Disorder: No Yes, Who:_____
    i. Heart Disease/Stroke: No Yes, Who: _____
    j. Weight problems: No Yes, Who:_____
    k. Symptoms of coronary disease, angina or heart attacks: No Yes, Who_____
20. Are you pregnant or planning pregnancy?_____ Planning to be? _____ Are you nursing ?_____

Weight/Diet:

1. Desired weight? _____ last date of desired weight? _____
2. Examples of eating habits before this program (avg. daily calorie intake)_____
   _____
3. Do you have parents and/or siblings who are overweight or obese? Yes No
4. Previous weight-loss attempts: _____
5. Have you taken appetite suppressants in the past? Yes No
6. How many pounds would you like to lose in a month? _____

Nutrition Evaluation:

1. What is the main reason for your decision to lose weight? _____
   _____
2. How often do you eat out? _____
3. What restaurants do you frequent? _____
4. How often do you eat "fast food"? _____
5. 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., at least three times per week

   _____ Vigorous activity –extensive physical exercise for at least 60 minutes 4 times per week

6. Does your family or significant others support your desire to lose weight? Yes No

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

There will be NO REFUNDS given once services are performed.

It is hereby agreed that any and all information and photographs, whether written, verbal, literature protocols or any other communications are considered proprietary and will not be used in any form or shared with any other persons or entities without the expressed written consent of Diet Solution Centers.

Signed: _____ **Date:** _____