WOMEN'S HEALTH
ADVANTAGE

MEDICAL HISTORY FORM

Patient Name _____ Age _____ Sex _____

Primary Care Physician _____

Home Phone _____ Cell Phone _____ Work Phone _____

Present Status

1. Are you in good health, to the best of your knowledge? YES ❑ NO ❑
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? *(list additional on the last page, if needed)* YES ❑ NO ❑
   What: _____ Dosage: _____
   What: _____ Dosage: _____
4. Any known allergies to medications? YES ❑ NO ❑
5. Any history to high blood pressure? YES ❑ NO ❑
6. Any history of diabetes? YES ❑ NO ❑
7. Any history of heart attack or chest pain? YES ❑ NO ❑
8. Any history of swelling feet? YES ❑ NO ❑
9. Any history of frequent headaches? YES ❑ NO ❑
   Migraines? YES ❑ NO ❑
   Medications for headaches: _____
10. Any history of constipation (difficulty in bowel movement)? YES ❑ NO ❑
11. Any history of issues with the prostate? *(males only)* YES ❑ NO ❑
    If yes, please explain: _____
12. Any surgeries? YES ❑ NO ❑
    Specify: _____ Date: _____
    Specify: _____ Date: _____

Past Medical History *(check all that apply)*

Polio	❑	Cancer	❑	Psychiatric Illness	❑	Tuberculosis	❑
Jaundice	❑	Osteoporosis	❑	Alcohol Abuse	❑	Drug Abuse	❑
Scarlet Fever	❑	Measles	❑	Typhoid Fever	❑	Pneumonia	❑
Whooping Cough	❑	Mumps	❑	Blood Transfusion	❑	Cholera	❑
Bleeding Disorder	❑	Liver Disease	❑	Tonsillitis	❑	Arthritis	❑
Gout	❑	Chicken Pox	❑	Pleurisy	❑	Other *(describe)*	❑
Heart Valve Disorder	❑	Nervous Breakdown	❑	Lung Disease	❑	_____	
Gallbladder Disorder	❑	Ulcers	❑	Rheumatic Fever	❑	_____	
Eating Disorder	❑	Thyroid Disease	❑	Ulcers	❑	_____	
Malaria	❑	Heart Disease	❑	Anemia	❑	_____	

Nutritional Evaluation

1. Present weight: _____ Present height (no shoes): _____ Desired weight: _____
   Weight one year ago: _____ Heaviest weight: _____
2. What is that main reason for your decision to lose weight? _____
3. When did you begin gaining excess weight? Give reasons, if known. _____
   _____
4. What has been your maximum lifetime weight (non-pregnant) and when? _____
5. (a) Previous diets you have followed. Give dates and results of your weight loss.
   _____
   (b) Previous medications or supplements taken for weight loss. Give dates and any side effects.
   _____
6. Is your spouse, fiancé, or partner overweight? YES ❑ NO ❑
   By how much is he/she overweight? _____
7. Who plans meals? _____ Cooks? _____ Shops? _____
8. Food allergies: _____
9. Do you drink coffee or tea? YES ❑ NO ❑ How much daily? _____
10. Do you drink soda? YES ❑ NO ❑ How much daily? _____
11. Do you drink alcohol? YES ❑ NO ❑ How much daily? _____
12. Do you use a sugar substitute? YES ❑ NO ❑
13. 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, four times per week.

14. Please describe your general health goals and improvements you wish to make.

_____

_____

_____

_____

15. List what you normally eat:

BREAKFAST	MID-AFTERNOON	SNACKS
MID-MORNING	**DINNER**	**BEVERAGES**
LUNCH	**EVENING**	**DESSERTS**

Gynecological History *(females only)*

1. Number of pregnancies: _____ Dates: _____
2. Are your periods regular? YES ❑ NO ❑
3. Any pain associated with periods? YES ❑ NO ❑
4. Last menstrual period: _____
5. Last gynecological exam: _____
6. Hormone replacement therapy? YES ❑ NO ❑ Type: _____
7. Birth control pills? YES ❑ NO ❑ Type: _____

   Specify: _____ Date: _____

Additional Medications *(if needed)*

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____