Hometown Healthcare
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Patient Name: _____

Medical History

Date: _____

Please list any medical conditions a medical provider has diagnosed you with in the past (such as high blood pressure, diabetes, arthritis, etc...): *

What medications, supplements and over the counter items do you take regularly or are currently prescribed: *

Any past surgeries and hospitalizations? *

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

You have problems falling or staying asleep?

How many hours do you sleep?

Does your energy level affect your daily activities?

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How would describe your mood, generally:

Does your mood affect your life or daily activities?

How would you describe your stress level?

What are your sources of stress?

How do you manage stress?

Do you regularly drink alcoholic beverages? Y N if yes, how many per week?

Do you smoke tobacco? Y

Do you use recreational drugs? Y N What:

How much: When:

Slow metabolism Family history of obesity

Comfort food dependency

Binge eating

History of trauma

History of grief and loss

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Diet and lifestyle

Typical Breakfast:

What: _____

How much: _____
When: _____

Typical Lunch:

What: _____

How much: _____
When: _____

Typical Dinner:

What: _____

How much: _____
When: _____

How often do you eat out? _____

Do you eat because of emotions (explain)?

_____

How much fluids do you normally drink? Please approximate in ounces.

_____

Please list all types of beverages you regularly drink.

_____
_____

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What past struggles and difficulties have you experienced in terms of food and dieting?

What diet and exercise programs, protocols, plans or approaches have you tried in the past?

What do you think is the cause of your weight problem?

What was your highest weight? (excluding pregnancy)

What was your lowest weight?

Have you ever stayed the same weight for 10 years or more?

How MOTIVATED are you to lose weight?

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Health History	No Never	Yes Currently	Not Currently, but within the past year	Not Currently and longer than 1 year
Fatigue				
Unexplained weight loss or gain				
Change in appetite				
Depressive Symptoms				
Anxiety				
Mood Swings				
Nervousness				
Addictive Dependency				
Disordered Eating Pattern/Tendency				
Tension				
Lack of mental focus				
Thyroid Problems				
Diabetes				
Blood sugar irregularities				
Excessive thirst or hunger				
Sugar Cravings				
Cold or Pale extremities				
Feeling excessively hot or cold				
Nausea				
Headache				
Lightheadedness				
Short of Breath				
Muscle weakness or soreness				
High Blood Pressure				
Heart murmur/palpitations				
Heartburn				
Abdominal Bloating/Discomfort after eating				
Belching/Gas				
Constipation				
Diarrhea				
Daily Bowel Movement				

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Patient Name:_____

Filled by the Physician

Plan of Care_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Weight Loss and BMI Tracker
