



**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...): \***

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

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**Any past surgeries and hospitalizations? \***

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

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**You have problems falling or staying asleep?**

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**How many hours do you sleep?**

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**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 N**

**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?**

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

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

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**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

Week	Day	Weight (kg)	BMI
1	1		
1	2		
1	3		
1	4		
1	5		
1	6		
1	7		
2	1		
2	2		
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