The Balanced Life Weight Loss History Form

[Pick the date]

Name:____**Date**:____/_____/__________

Age:___________ **Sex:** ρ **M** ρ **F** **Date of Birth**:__________________**Phone**:________________________________

Family Physician:________________________________**Facility**____

1. Are you in good health at the present time to the best of your knowledge: ρ **Yes** ρ **NO**
2. Are you under a doctor's care at the present time? ρ **Yes** ρ **No**
If yes what for? ____
3. Are you taking any medications at the present time? ρ **Yes** ρ **No**
Medication:______________________Dosage:________________Medication:_________________Dosage_____________

Medication:______________________Dosage:________________Medication:_________________Dosage:____________

General History:

4. Any Allergies to any medications? ρ **Yes** ρ **No**

5. High Blood Pressure? ρ **Yes** ρ **No**

6. Diabetes: ρ Yes ρ No

7. Heart Attack or Chest Pain ρ Yes ρ No

8. Swelling Feet? ρ Yes ρ No

9. Frequent Headaches, muscle aches, joint aches/pains or back pain? ρ Yes ρ No
Location of
Pain:____
Migraines ρ Yes ρ No
Medication for headaches or other aches, pains or muscular
conditions:____
10. Constipation (difficulty in bowel movements)? ρ Yes ρ No

11. Gynecologic History:

Pregnancies: ρ Yes ρ No Number:___________Years:____________Weight Gained/
Pregnancy_____________________________

Weight Lost/Pregnancy_________________________

Menstrual: Onset: ________________Duration:______________ Is Menstruation Regular? ρ Yes ρ No

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Pain Associated with Menstruation? ρ Yes ρ No

Last Menstrual Period:_______________________________

Hormone Replacement Therapy: ρ Yes ρ No

Birth Control Pills: ρ Yes ρ No Type:_______________________
Last Medical Check Up:____

12. Serious Injuries: ρ Yes ρ No

Specify:____
Date:_______________________

13. Surgeries: ρ Yes ρ No

Specify;____
Date:_______________________

Specify;____
Date:_______________________

15.

Family History	Age	Health	Disease	Cause of Death	Overweight?

Has any blood relative ever had any of the following:

Glaucoma: ρ Yes ρ No

Asthma: ρ Yes ρ No

Epilepsy: ρ Yes ρ No

High Blood Pressure: ρ Yes ρ No

Kidney Disease: ρ Yes ρ No

Diabetes: ρ Yes ρ No If yes, ρ Type 1 ρ Type 2

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Past Medical History

ρ Polio ρ Measles ρ Tonsillitis ρ Jaundice ρ Mumps

ρ Pleurisy ρ Kidneys ρ Scarlet Fever ρ Liver Disease ρ Lung Disease

ρ Whooping Cough ρ Chicken Pox ρ Rheumatic Fever ρ Bleeding Disorder ρ Anxiety

ρ Ulcers ρ Gout ρ Thyroid Disease ρ Anemia ρ Heart Valve Disorder

ρ Heart Disease ρ Tuberculosis ρ Gallbladder Disorder ρ Psychiatric Illness

ρ Drug Abuse ρ Eating Disorder ρ Alcohol Abuse ρ Pneumonia
ρ Typhoid Fever ρ Cholera ρ Cancer ρ Arthritis ρ Osteoporosis

ρ Other Please
Explain____
____
____
____
____

Nutrition Evaluation:

1. Present Weight:___________Height (no shoes): ________________Desired Weight:______________

   Weight one year ago:____________.

2. In what time frame would you like to be at your desired weight?______________________________________

3. What is the main reason for your decision to lose weight?____

4. When did you begin gaining excess weight? (Give reasons, if known):_________________________________

5. What has been your maximum lifetime weight (non-pregnant) and when?____________________________

6. Previous diets you have followed: Give diet types and results of your weight loss:

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7. Is your spouse, fiancée or partner overweight: ρ Yes ρ No

8. By how much is he of she overweight:____

9. How often do you eat out?____

10. What restaurants do you frequent?____

11. How often do you eat “fast foods?” ____

12. Who plans meals? _____________________ Cooks?_____________________ Shops?_________________________

13. Do you use a shopping list? ρ Yes ρ No

14. What time of day, and on what day do you shop for groceries?_________________________________

15. Food Allergies?____

16. Food Dislikes?____

17. Food You Crave?____

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18. Any specific time of the day or month do you crave food?____________________________________

19. Do you drink coffee or tea? ρ Yes ρ No How much daily?________________________________

20. Do you drink cola drinks? ρ Yes ρ No How much daily?_________________________________

21. Do you drink Alcohol? ρ Yes ρ No What?___________ How much? __________Weekly?____________

22. Do you use a sugar substitute? ρ Yes ρ No Butter? ρ yes ρ No Margarine? ρ Yes ρ No

23. Do you awaken hungry during the night? ρ Yes ρ No

    What do you do?____

24. What are your worst food habits?____

25. Snack Habits: What? _____________________ How much? ______________________ When:__________________

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26. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

___

27. Do you think you are currently undergoing a stressful situation or an emotional upset?
Explain:____
____

28. Smoking Habits: (Answer only one)

- ρ You have never smoked cigarettes, cigars or a pipe.
- ρ You quit smoking years ago and have not smoked since.
- ρ You currently smoke.

29.

Typical Breakfast	**Typical Snack**	**Typical Lunch**	**Typical Snack**	**Typical Dinner**
____________	____________	____________	____________	____________
____________	____________	____________	____________	____________
____________	____________	____________	____________	____________
____________	____________	____________	____________	____________
Time:________	____________	____________	____________	____________
Where:_______	____________	____________	____________	____________
With whom:____	____________	____________	____________	____________

30. Describe you usual energy level:_______________________________________

31. **Activity Level: (answer only one)**

- ρ Inactive – no regular physical activity with a sit-down job.
- ρ Light Activity—no organized physical activity during leisure time.
- ρ Moderate Activity—Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling.
- ρ 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.
- ρ Vigorous activity participation in extensive physical exercise for at least 60 minutes per session 4 times per weak.

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32. Behavior Style (Answer only One)

- ρ You are always calm and easygoing.
- ρ You are usually calm and easygoing.
- ρ You are sometimes calm with frequent impatience.
- ρ You are seldom calm and persistently driving for advancement.
- ρ You are never calm and have overwhelming ambition.
- ρ You are hard driving and can never relax.

33. Please describe your general health goals and improvements you wish to make: 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.____

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