Medical History

General
Last Name: ___________________________ First Name: _________________________

Date of Birth: _______________ Age: _____ Contact Number: _____________________

Are you in good health to the best of your knowledge □ Yes □ No

Medical Information:
Please list any physicians you see and their specialty:
____
____
____
____

Are you taking any medications at the present time? LIST ALL

Name of Medication **Reason**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Allergies:
Do you have any **food** allergies? □ Yes □ No
If so, please list: ____
Do you have any **medication** allergies? □ Yes □ No
If so, please list: ____

Cardiovascular Health:
Do you have history of arrhythmia (irregular heart beat) □ Yes □ No
Have you had a heart attack or chest pain □ Yes □ No
Do you have **high blood pressure?** □ Yes □ No
Are you taking medication for blood pressure: □ Yes □ No
Do your feet or ankles swell? □ Yes □ No
High cholesterol? □ Yes □ No

Blood Sugar or Diabetes:
Do you tend to be hypoglycemic? □ Yes □ No
Do you have diabetes? □ Yes □ No (if no, skip to next section)
□ Type I – insulin dependent (insulin injections only);
□ Type II – non-insulin dependent (diabetic pills);
□ Type II – insulin dependent (diabetic pills and insulin).
Is your blood sugar level monitored? □ Yes □ No
If so, by whom? □ Myself □ Physician □ Other (specify): _________________
Are you taking any medication for diabetes? □ Yes □ No

Kidney Health:
Have you been diagnosed with kidney disease? □ Yes □ No
Have you ever had Gout? □ Yes □ No

Liver Health:
Do you have liver problems? □ Yes □ No If so, please specify:

Colon Health:
Do you have: □ Irritable Bowel □ Colitis □ Diarrhea □ Diverticulosis □ Crohn's disease □ Constipation
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

Stomach/Digestive Health:
Do you have: □ Acid Reflux □ Gastric Ulcer □ Heartburn □ Celiac Disease?
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

Thyroid Function:
Do you have thyroid problems? □ Yes □ No
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

***Emotional Evaluation*:**
Do any of the following apply to you? □ Yes □ No
□ Depression □ Anxiety □ Panic Attacks □ Bulimia (or history of) □ Anorexia (or history of)

Inflammatory Conditions:
Do any of the following apply to you? □ Yes □ No
□ Migraines □ Fibromyalgia □ Rheumatoid Arthritis □ Lupus □ Osteoarthritis □ Chronic Fatigue Syndrome
□ Psoriasis □ Other autoimmune or inflammatory condition:

Headaches:
□ History of frequent headaches □ Migraine? □ Medications for headaches?

General:
Do you now or have you ever had cancer? □ Yes □ No

Are you in cancer remission? □ Yes □ No
If so, please specify and indicate for how long: ____________________________
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list: ____

Are you generally fatigued or have low energy? □ Yes □ No
Do you get cold easily? □ Yes □ No
Do you have cold hands/feet? □ Yes □ No

Do you have other health problems? □ Yes □ No
If so, please specify: ____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medications not listed above? □ Yes □ No
If so, please list: ____

(Women only): □ Not applicable
Are you pregnant? □ Yes □ No
Are you breastfeeding? □ Yes □ No

Pregnancies: #_____ Dates: ____

Date of last menstrual cycle **if** still having periods: _________
Approximate date or year of last cycle if no longer having periods: _______________

Check off the situations that apply to you currently:

□ Irregular Periods □ Amenorrhea □ Painful Periods □ Heavy periods □ Hysterectomy □ Menopause
□ Hormone Replacement therapy (HRT) □ Uterine fibroma □ Fibrocystic Breasts □ Cancer (uterus, breast)

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:

Vitamin and mineral Supplements: Please List what you currently take

Current Vitamin, Herb or Supplement Name **Reason**

1. ____
2. ____
3. ____
4. ____
5. ____

	Age	Diseases?	Cause of death	Overweight?
FATHER				YES NO
MOTHER				YES NO
BROTHERS				YES NO
SISTERS				YES NO
				YES NO

Has any blood relative had the following?

Glaucoma YES NO Who: ____________________
Asthma YES NO Who: ____________________
High Blood Pressure YES NO Who: ____________________
Kidney disease YES NO Who: ____________________
Diabetes YES NO Who: ____________________
Tuberculosis YES NO Who: ____________________
Psychiatric disorder YES NO Who: ____________________
Heart Disease/ Stroke YES NO Who: ____________________

	PAST MEDICAL HISTORY		**(CHECK ALL THAT APPLY)**		
	POLIO		MEASLES		PLEURISY
	JAUNDICE		MUMPS		LUNG DISEASE
	SCARLET FEVER		LIVER DISEASE		RHEUMATIC FEVER
	WHOOPING COUGH		CHICKEN POX		ULCERS
	BLEEDING DISORDER		NERVOUS BREAKDOWN		ANEMIA
	GOUT		THYROID DISEASE		TUBERCULOSIS
	HEART VALVE DISORDER		HEART DISEASE		DRUG ABUSE
	GALLBLADDER DISORDER		PHYCHIATRIC ILLNESS		PNEUMONIA
	EATING DISORDER		ALCOHOL ABUSE		CHOLERA
	MALARIA		TYPHOID FEVER		ARTHRITIS
	CANCER		BLOOD TRANSFUSION		TONSILLITIS
	OSTEOPOROSIS		OTHER (DESCRIBE)		

I hereby certify the information I have provided is accurate. I understand that inaccurate information may adversely affect the outcome of my weight loss program.

Signature________________________________ Date____________________________

PATIENT INFORMATION QUESTIONNAIRE

TO HELP US SERVE YOU BETTER, PLEASE COMPLETE THIS QUESTIONNAIRE BY CHECKING THE APPROPRIATE BOXES AND EXPLAINING WHERE APPLICABLE!

LAST NAME ______________________ **FIRST NAME** ______________________ **DATE** ______________

1. Does your extra weight make you feel uncomfortable? YES NO SOMETIMES

2. Has your clothing size increased in the past two years? YES NO
   If yes, from size _____ to size _____

3. Present Age: _____ What was your weight when you felt you were at your best? _____
   What was your age then? ____

4. Present Weight: _____Dress/Slack Sz: _____Desired Weight: _____ Desired Dress/Slack Sz: _____

5. What was your heaviest weight? _____ Your age then: _____When did you start to gain weight? _____ How long did it take you to gain the excess weight? ___________

6. What, if anything, had you done previously to lose weight? Exercise ☐ Pills ☐
   Fasting ☐ Diet ☐ If diet, where?______________

7. How successful were you? Very Good ☐ Good ☐ Average ☐ Poor ☐

9. Have you gained weight since then? YES NO
   If yes, why? ____

10. How long does it normally take you to lose weight? ______________________

11. Do you take vitamins or other food supplements when you diet? YES NO

12. Which describes you best? I eat too much: When nervous ☐ For pleasure ☐
    When upset ☐ Other ☐ ____________________

13. List what you normally eat for:

BREAKFAST	MIDAFTERNOON	SNACKS
MIDMORNING	**DINNER**	**BEVERAGES**
LUNCH	**EVENING**	**DESSERTS**

HWFORM 217.1

14. A normal diet for me includes approximately _____ calories per day.

15. Where do you usually eat your meals? Kitchen ☐ Dining Room ☐ Living Room ☐
Other ______________

16. Do you take time to plan and cook your meals? YES NO
Do you prefer fast foods? YES NO

17. How do you reward yourself for dieting? ____________________________________

18. Have you ever felt tired, or hungry, while dieting? YES NO SOMETIMES

19. What does your doctor think of your weight? You Should Lose ☐ You Shouldn't Lose ☐
No Opinion ☐

20. Do those close to you wish you would take part in a weight-loss program? YES NO
If yes, who? ______________________________

21. Did anyone ever encourage you during a diet before? YES NO If yes, who?______________

22. Is your dieting more successful when friends or family members diet with you? YES NO

23. Will your family/friends help you diet? YES NO
If not, who will you turn to for support? ______________________

24. How important do you think it is to have a diet partner? VERY NOT VERY NO OPINION

25. Do you know how much weight you can expect to lose each week on our program? YES NO

26. Do you know why you would lose weight so fast on a KETOGENIC diet? YES NO

27. Would you have objections to following the weight loss program given to you by our staff?
YES NO If yes, please list objections: ___________________________

28. Were you ever on a diet that was not easy and safe? YES NO
If yes, please explain: ____

29. Why is it important for you to lose weight? Self-Esteem☐ Appearance ☐
Doctor's Suggestions ☐ Tight Clothes ☐ General Health ☐
Upcoming Event ☐ Other ☐ If other, please explain: _______________

30. What brought you to our clinic? Newspaper Ad ☐ Phone Solicitation ☐ Friend ☐
Other _____________

COMMENTS: ____

____

HWFORM 217.2

RIV080312

NUTRITIONAL EVALUATION:

1. Present weight ________ Present height (no shoes) _____ Desired weight _______
2. In what time frame would you like to be at your desired weight?
3. Birth Weight: _______ Weight at 20 years of age: _______
   Weight one year ago: _______
4. What is the main reason for your decision to lose weight? ____________________
5. When did you begin gaining excess weight? (Give reasons, if known) ____________
   ____
6. What has been your maximum lifetime weight (non-pregnant) and when? __________
7. (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. ________________________________
8. Is your spouse, fiancée, or partner overweight? YES NO
   By how much is he (or 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? YES NO
14. What time of day do you shop for groceries? _________ what day? ___________
15. Food Allergies: ________________________________
16. Food Dislikes: ________________________________
17. Foods You Crave: ________________________________
18. Any specific time of the day or month that you crave food? YES NO
    ____
19. Do you drink coffee or tea? YES NO How much daily? ______________
20. Do you drink cola drinks? YES NO How much daily? ______________
21. Do you drink alcohol? YES NO What? _________ How much? ________
    How often? __________
22. Do you use a sugar substitute? YES NO Butter? YES NO
    Margarine? YES NO
23. Do you awaken hungry during the night? YES NO
    What do you do? ________________________________
24. What are your worst food habits? ____________________________
25. Snack Habits: What? ________________________________
    How much? _________ When? ______________________

26. When you are under a stressful situation at work, or family related, do you tend to eat more? YES NO Explain ______________________________

27. Do you think you are currently undergoing a stressful situation or an emotional upset? YES NO Explain: ______________________________

28. Smoking Habits:
Do you currently smoke? YES NO If yes, how much per day? __________
Have you smoked in the past? YES NO If yes, when did you quit? ________

29. Typical Eating Habits:

TYPICAL BREAKFAST	TYPICAL LUNCH	TYPICAL DINNER
Time Eaten:	Time Eaten:	Time Eaten:
Where:	Where:	Where:
With Whom:	With Whom:	With Whom:

30. Describe your usual energy level: ______________________________

31. 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, 4 times per week.

32. Behavior Style: **(Answer Only One)**
- __ I am always calm and easy-going
- __ I am usually calm and easy-going
- __ I am sometimes calm with frequent impatience
- __ I am seldom calm and persistently driving for advancement
- __ I am never calm and have overwhelming ambition
- __ I am hard-driven 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.

DIET READINESS SELF-ASSESSMENT

For each question, circle the answer that best describes how you feel. There are no right or wrong answers. Be as honest as you can be with yourself.

SECTION 1: GOALS AND ATTITUDES

1. Compared to other attempts, are you motivated to lose weight this time? **(Circle only one)**

    1. Not Motivated
    2. Slightly Motivated
    3. Somewhat Motivated
    4. Very Motivated
    5. Highly Motivated

2. How certain are you that you will be committed to a weight loss program for the time it will take to reach your goal? **(Circle only one)**

    1. Not at all Certain
    2. Slightly Certain
    3. Somewhat Certain
    4. Very Certain
    5. Extremely Certain

3. Consider all outside factors at this time in your life. Will you be able to make the effort required to stick to a diet? **(Circle only one)**

    1. Cannot make the effort to handle outside factors.
    2. Can handle some of the outside factors.
    3. Can probably handle most of the outside factors.
    4. Can handle most of the outside factors.
    5. Can do whatever I need to do to handle the outside factors.

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic are your expectations? **(Circle only one)**

    1. Very Unrealistic
    2. Somewhat Unrealistic
    3. Moderately Unrealistic
    4. Somewhat Realistic
    5. Very Realistic

5. While dieting, do you think about eating a lot of your favorite foods? **(Circle only one)**

    1. Always
    2. Frequently
    3. Occasionally
    4. Rarely
    5. Never

6. While dieting, do you feel deprived, angry and/or upset? **(Circle only one)**

    1. Always
    2. Frequently
    3. Occasionally
    4. Rarely
    5. Never

SECTION 2: HUNGER AND EATING CUES

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?**(Circle only one)**

    1. Never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Always

8. How often do you eat because of **physical hunger**? **(Circle only one)**

   1. Always
   2. Frequently
   3. Occasionally
   4. Rarely
   5. Never

9. If your favorite foods are around the house, do you have trouble controlling urges? **(Circle only one)**

   1. Never
   2. Rarely
   3. Occasionally
   4. Frequently
   5. Always

SECTION 3: CONTROLLING EATING

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal. **(Circle only one)**

    1. Would Eat Much Less
    2. Would Eat Somewhat Less
    3. Would Make No Difference
    4. Would Eat Somewhat More
    5. Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food. **(Circle only one)**

    1. Would Eat Much Less
    2. Would Eat Somewhat Less
    3. Would Make No Difference
    4. Would Eat Somewhat More
    5. Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat. **(Circle only one)**

    1. Would Eat Much Less
    2. Would Eat Somewhat Less
    3. Would Make No Difference
    4. Would Eat Somewhat More
    5. Would Eat Much More

SECTION 4: BINGE EATING AND PURGING

13. Aside from holidays, have you ever eaten a large amount of food rapidly and felt that your eating was out of control? **(Circle only one)**

    4 Yes
    0 No

14. If you answered yes to #13 above, how often have you engaged in this behavior during the last year? **(Circle only one)**

    1. Less Than Once A Month
    2. About Once A Month
    3. A Few Times A Month
    4. About Once A Week
    5. About Three Times A Week
    6. Daily

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight? **(Circle only one)**

    3 Yes
    0 No

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year? **(Circle only one)**

    1. Less Than Once A Month
    2. About Once A Month
    3. A Few Times A Month
    4. About Once A Week
    5. About Three Times A Week
    6. Daily

SECTION 5: EMOTIONAL EATING

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?**(Circle only one)**

    1. Never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Always

18. Do you have trouble controlling your eating when you have positive feelings? Do you celebrate feeling good by eating? **(Circle only one)**

    1. Never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Always

19. When you have interpersonal stress, or after a difficult day at work, do you eat more than you'd like? **(Circle only one)**

    1. Never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Always

SECTION 6: EXERCISE PATTERNS AND ATTITUDES

20. How often do you exercise? **(Circle only one)**

    1. Never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Always

21. Within your physical limitations, do you believe that you can exercise regularly? **(Circle only one)**

1. Not At All
2. Slightly
3. Somewhat
4. Highly
5. Completely Confident

22. When you think about exercise, do you develop a positive or negative picture in your mind? **(Circle only one)**

1. Very Negative
2. Somewhat Negative
3. Neutral
4. Somewhat Positive
5. Completely Positive

23. How certain are you that you can work regular exercise into your daily schedule? **(Circle only one)**

1. Not At All Certain
2. Slightly Certain
3. Somewhat Certain
4. Quite Certain
5. Extremely Certain