

**FIRST HEALTH ASSOCIATES - Weight Loss Fitness
Patient Initial Medical History Form**

Patient Name: _____ Date of Birth _____ Date: _____

Did you complete the general medical history form? Yes No

Nutrition / Weight History

What is your current weight: _____ Height _____ What is your goal weight: _____

Do you have specific fitness goals besides weight loss: _____

If you are not at your goal weight:

In what time frame would you like to be at your desired weight: _____

What is the main reason you would like to change your weight: _____

At what age did you first feel like you were not the weight you wanted: _____

What has been your highest (non-pregnant) weight, and when: _____

Have you tried to lose weight before: Yes No

In the past year? Number of attempts: _____

If yes, what did you try:

Commercial diet program, such as Weight Watchers or Jenny Craig

If so, which one(s): _____

Prescribed diet plan, such as Atkins, The Zone

If so, which one(s): _____

Exercise with trainer? Yes No

Exercise at home program, such as Wii Fit, or DVD program

If so, which one(s): _____

Weight loss medication: Yes No

If so, which one(s): _____

If yes to any of the above, please give dates and results:

Date / Program / Results (start weight, end weight)

- _____

- _____

- _____

Patient Signature: _____ Date _____

Social Factors / Food Preferences

Who lives at home with you (spouse, children, etc): _____

Who plans meals: _____ Who Cooks: _____ Who shops: _____

Are the other people in the household overweight Yes No

Do you have obese blood relatives (if so, what is there relationship to you)? _____
- _____

Do you have family members with health issues related to obesity (high blood pressure, diabetes, etc); if so, who, what is their relation to you, and what problems do they have?
- _____
- _____

How often do you eat out (per week): _____

How often do you eat a meal in the car (per week): _____

How often do you eat a meal in front of the television or computer (per week): _____

What foods do you like: _____

What foods do you dislike: _____

Do you eat after 11PM Yes No

How many times per week: _____

Do you drink soft drinks, coffee, tea ? Yes No

Which and how much daily: _____

What is a typical first meal of the day: Time, food type and amount: _____
- _____

What is a typical second meal of the day: Time, food type and amount: _____
- _____

What is a typical third meal of the day: Time, food type and amount: _____
- _____

What are typical snacks of the day: Time, food type and amount: _____

Do you smoke tobacco: Yes No If yes, how much per day: _____

If no, have you ever: Yes No If yes, last time smoking: _____

How much alcohol do you consume in a week? _____

Patient Signature: _____ Date: _____

Psychological History

Have you ever received treatment for any psychological condition (such as depression, anxiety, anger management, eating disorder, marriage counseling, etc) : Yes / No

Specify (condition/date/treatment): _____

Have you ever felt the need for counseling, psychiatric/psychological treatment (even if you did not get treatment at that time): Yes No

If so, why: _____

Do you feel that stress is affecting your life: Yes No How: _____

Do you feel that stress affects how you eat: Yes No How: _____

Have you ever taken medications for psychological / psychiatric reasons: Yes No

If yes, which ones, and when: _____

From 1-10 (10 is perfectly satisfied), how satisfied are you with the following:

Marriage/relationship: ____ Family/children: ____ Work: ____ Finances: ____

Fitness assessment

During a normal week how many minutes do you spend at the following activity levels:

Light activity (more than sitting, but will not make you sweat): _____

Moderate activity (activities that will make you sweat): _____

Heavy activity (activities that make it hard to talk normally): _____

Intense activity (activity at your peak level of exertion): _____

Which activities are you likely to participate in on your own to improve fitness (please circle):

Running/jogging, Cycling, Swimming, Exercise class (aerobics), Sports etc.

Are there any physical activities that you feel that you are unable to perform:

Specify: _____

Is there any additional information that you would like to provide at this time?

- _____
- _____
- _____
- _____

Patient Signature: _____ Date: _____