

List all things to which you are allergic (including medication):

Type of Reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History:

Father's present age: _____ or age at death: _____ Cause of death: _____

Health problems: _____ Obesity? Yes / No

Mother's present age: _____ or age at death: _____ Cause of death: _____

Health problems: _____ Obesity? Yes / No

Names & ages of brothers and/or sisters and health problems. Please include stepbrothers/stepsisters:

1. _____ Obesity? Yes / No
2. _____ Obesity? Yes / No
3. _____ Obesity? Yes / No
4. _____ Obesity? Yes / No
5. _____ Obesity? Yes / No
6. _____ Obesity? Yes / No
7. _____ Obesity? Yes / No
8. _____ Obesity? Yes / No

Women

Men

Number of Pregnancies _____

Date of last testicular exam _____

Number of children delivered _____

Date of last prostate exam _____

Number of children now living _____

Date of Last Menstrual Period _____

Are your menstrual cycles: regular irregular heavy light no longer menstruating
(circle all that apply please)

Date of Last Mammogram _____

Date of Last PAP smear _____

Names & ages of your children:

1. _____ Obesity? Yes / No

2. _____ Obesity? Yes / No

3. _____ Obesity? Yes / No

4. _____ Obesity? Yes / No

5. _____ Obesity? Yes / No

Social History:

What is the highest grade completed? _____

Do you smoke? Yes / No How many cigarettes a day? _____

When did you stop smoking? _____

Do you drink alcohol? Yes / No How much alcohol do you drink in a week? _____

Have you ever been addicted to alcohol? Yes / No Ever in treatment for alcohol addiction? Yes / No

Do you use illicit drugs? Yes / No What drug(s)? _____

When did you last use drug(s)? _____ Ever in treatment for drug addiction? Yes / No

Who do you live with? _____

Do you currently participate in any exercise activity? Yes / No If so, what type of exercise do you do and how long (minutes) do you exercise? _____

How often do you exercise? _____

I have carefully completed all the forms and have reported all of my medical history and do verify it to be true and correct**

Signature of Patient

Date