



DATE _____

In an effort to serve you better, we request that you answer the following questions. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent. If a question doesn't pertain to you, please ignore. Thank you!

LAST NAME: _____ FIRST NAME: _____ AGE: _____

MEDICAL HISTORY

Current weight (approximate): _____ Height (approximate): _____

Weight 1 year ago _____ Min. Adult Weight _____ at age _____ Max Adult Weight _____ at age _____

CIRCLE ANY OF THE CONDITIONS THAT YOU HAVE HAD

ALLERGIES

GALLBLADDER DISEASE

METABOLIC SYNDROME

ASTHMA

GASTRIC REFLUX

NEUROPATHY (NUMBNESS)

BLOOD CLOTS

GASTRIC SURGERY

OSTEOARTHRITIS

CANCER*

GOUT

PAIN*

CHRONIC BACK PAIN

HEADACHES

PRE-DIABETES

DEMENTIA

HEART DISEASE*

SKIN CONDITIONS

DEPRESSION

HIGH BLOOD PRESSURE

SLEEP APNEA

DIABETES

HIGH CHOLESTEROL

SOFT TISSUE DISEASE

FATTY LIVER

KIDNEY DISEASE

STROKES

THYROID DISEASE

*PLEASE DESCRIBE CONDITION IN DETAIL _____

LIST ANY SURGERIES YOU HAVE HAD AND WHEN

MEDICATIONS, PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDE STEROID MEDICATIONS, THYROID, OR CONTRACEPTION

MEDICATION/DOSE	FOR WHAT?	MEDICATION/DOSE	FOR WHAT?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CIRCLE ANY THAT APPLY

CHEST PAIN

INDIGESTION OR HEARTBURN

RAPID OR IRREGULAR HEART BEAT

NAUSEA AND/OR VOMITING

SHORTNESS OF BREATH

CONSTIPATION

CHRONIC COUGH

DIARRHEA

SWELLING OF LEGS AND/OR FEET

CRAMPING OR BLOATING

IF FEMALE, CAN YOU GET PREGNANT?: _____ IF SO, WHAT BIRTH CONTROL ARE YOU, OR YOUR PARTNER, USING? _____

ALLERGIES TO MEDICATIONS: _____ ALLERGIES TO FOOD? _____

IF SO, PLEASE EXPLAIN: _____

DO YOU EXERCISE? _____ IF SO, WHAT? _____

HAS YOUR DOCTOR RESTRICTED YOU FROM EXERCISING? _____

HAVE YOU EVER SMOKED? _____ IF YES, DO YOU STILL SMOKE? _____

DO YOU DRINK ALCOHOL? _____ HOW OFTEN? _____

HAVE YOU TRIED ANY DIETS IN THE PAST? _____ IF SO, WHAT _____

IS THERE ANYTHING YOU WOULD LIKE US TO KNOW?

SIGNATURE _____ DATE _____

THANK YOU FOR THIS VERY IMPORTANT INFORMATION