Hendricks FOR HEALTH

MEDICAL HISTORY FOR -

Patient Name _____ DOB _____

Does anyone in your family have:	**No**	**Yes**	**Comments: If yes, explain:** ***My Family***
Obesity or excessive weight?			
Alcoholism or drug abuse? You?			
High blood pressure?			
Diabetes?			
Coronary heart disease?			
Arteriosclerosis or stroke?			
High cholesterol?			
Gallstones?			
Have you or are you now:	**No**	**Yes**	**Comments: If yes, explain:** ***Me***
Headaches? What do you take for them?			
Vision problems? Glaucoma?			
Hearing problems?			
Sinus infections?			
Thyroid problems?			
Lung problems, e.g. pneumonia, asthma?			
Heart problems or high blood pressure?			
Gastrointestinal problems, ulcer, colitis?			
Hepatitis or jaundice?			
Gall bladder problems?			
Urinary bladder problems?			
Kidney problems?			
Arthritis?			
Muscle weakness or paralysis?			
Diabetes or metabolic disorder?			
High cholesterol levels?			
Anemia or blood disorder?			
Depression or anxiety?			
Sleeping disorder?			
Excessive snoring?			
Men: Have you had any prostate problems?			
Women**:** Had any pregnancies?			If so, how many?
When was your last period?			
Have you had any female problems?			
When was your last pelvic & Pap exam?			
Have you had breast problems?			
Any breast biopsies?			
Have you:	**No**	**Yes**	**Comments: If yes, explain:** ***Me***
Had any operations?			
Had any hospitalizations?			
Gastric Bypass Surgery?			What date?
Weight reduction surgery or procedures?			Weight loss amount?
Enrolled in a weight control program?			

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:	

Continued on back

Allergies

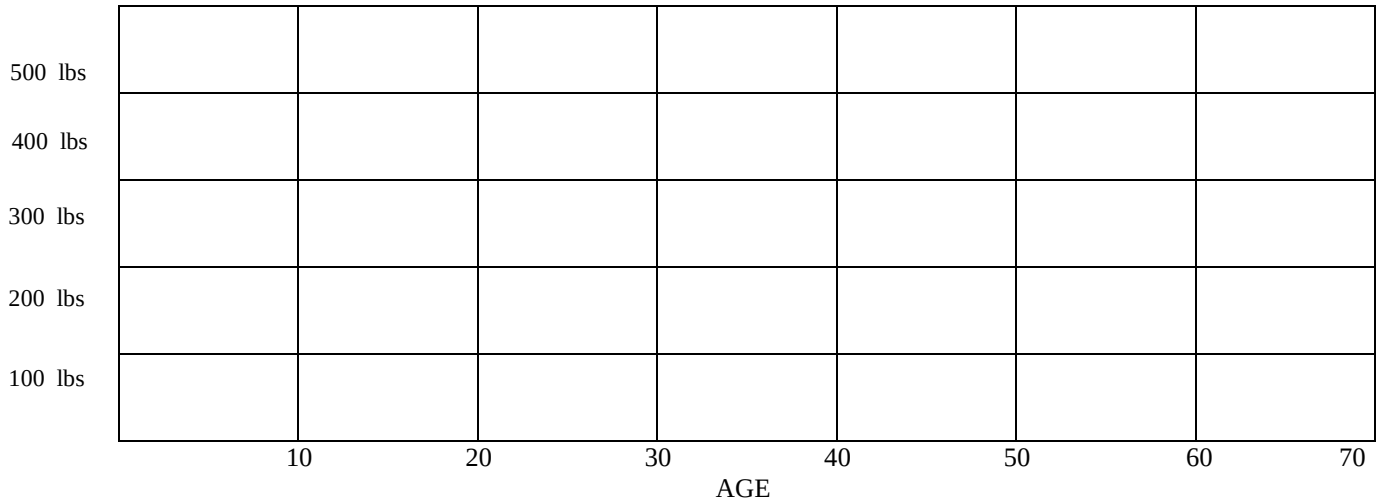
Have you or are you now:	No	Yes	Comments: If yes, List: *Me*
Have any allergies to medicines?			
Seasonal allergies?			
Food allergies?			
Dietary Restrictions?			

Weight Information

Have you been advised by your primary care physician or other medical professional to lose weight? Yes □ No □
Has your family encouraged you to lose weight? Yes □ No □ What is your height: _____ ft / _____inches
What is your approximate weight: _____ Desired weight: _____ Highest weight: _____
How long has it been since you were at your desired weight? _____ What was weight at age 18? _____
Has your weight been stable for a long time during your adult years? Yes □ No □ If yes, at what weight?_____
Have you taken Phentermine or any other anti-obesity medication(s) before? Yes □ No □
If yes, what medications have you taken:

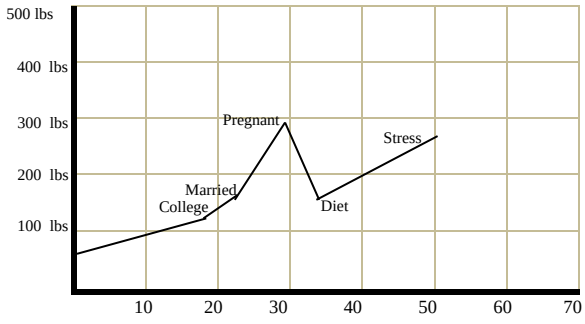
Habits & Your Health

Are you a water drinker? Yes □ No □ Do you drink alcohol? Yes □ No □ Do you drink every day? Yes □ No □
Do you smoke cigarettes? Yes □ No □ When did you start smoking? _____ How many do you smoke in a day? ____
Do you take any illicit drugs? Yes □ No □ If yes, what? _____
Do you like to exercise? Yes □ No □ Are you exercising regularly? Yes □ No □ Any exercise restrictions? Yes □ No □
If yes, explain: _____
Do you consider your health to be: Excellent □ Good □ Poor □



Draw an unbroken line with your weight versus your age. Include your weight gains and weight losses and mark significant times or events. Be sure to include your highest weight and your lowest adult weight.

Example:



Patient Signature _____ Date_____