Diet by Design

MEDICAL HISTORY AND SCREENING FORM

This is your medical history form, to be completed prior to you beginning your program. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our program. Please take your time and complete it carefully and thoroughly. Your answers will help us design a comprehensive program that meets your individual needs.

Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Occupation:

Position _____ Employer _____

Address _____

Phone _____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Does your heart often race?
- ☐ Are your ankles often badly swollen?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Has a doctor ever told you your cholesterol level was high?

Comments: _____

_____

_____

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Do you now have or have you recently experienced:

- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation, or diarrhea?
- ☐ Pregnant/Breast Feeding?
- ☐ Ovarian Cyst
- ☐ Prostate or Testicular Cancer
- ☐ Gout
- ☐ Gall bladder/Gastrointestinal issues
- ☐ Kidney disease
- ☐ Heart Disease
- ☐ Type 1 Diabetes
- ☐ HIV/AIDS
- ☐ Bypass Surgery
- ☐ Organ Transplant

Comments: _____

_____

_____

Women only answer the following. Do you have?

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?

Date of the last pelvic exam and / or Pap smear _____

Comments: _____

Are you on any type of hormone replacement therapy? _____

Men and women answer the following:

List any prescription medications you are now taking: _____

_____

_____

List any over the counter medications, dietary supplements, or vitamins you are now taking: _____

_____

_____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ can't remember

List any other medical or diagnostic test you have had in the past two years: _____

_____

List hospitalizations, including dates of and reasons for hospitalization within the last two years: _____

_____

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List any drug allergies:_____

_____

Past Medical History
Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Jaundice or gall bladder problems

Comments: _____

_____

Diet
What do you consider a good weight for yourself? _____

What is the most you have ever weighed (including when pregnant)? _____

One year ago my weight was: _____

How often do you drink alcoholic beverages?

☐ None ☐ Occasional ☐ Often If often, _____ per week

Comments: _____

_____

_____ _____
Patient Signature Staff Signature

_____ _____
Date Date