Rowan Medicine
Center for Medical Weight Loss & Metabolic Control
Dr. Adarsh K. Gupta
(856) 566-7020

Health History Questionnaire

Name: _____ M___ F___ DOB: _____

Previous or referring doctor: _____ Date of last physical exam: _____

Personal Health History

How would you rate your health? ___ Excellent ___ Good ___ Fair ___ Poor

Present Weight (lbs): _____ Height (inches): _____ Desired Weight: _____

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

What is the main reason for your decision to lose weight? _____

_____

_____

_____

Does your family support your efforts to lose weight? ___ Yes ___ No

Is your family overweight or obese? ___ Yes ___ No

Do you suffer from any of these health conditions?

___ High Blood Pressure ___ High Cholesterol ___ Diabetes ___ COPD ___ Asthma

___ Heart Disease (Heart Attach or Chest Pain) ___ Arthritis (Joint Pains)

List any medical problems that other doctors have diagnosed _____

_____

Surgeries (Year and Reason) _____

_____

Other hospitalizations _____

_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements

_____

Allergies to medications _____

_____

Health History Questionnaire

Health Habits and Lifestyle

Exercise

___ Sedentary (little or no exercise)

___ Lightly Active (light exercise/sports 1-3 days/week)

___ Moderately active (moderate exercise (sports 3-5 days/week

___ Very Active (hard exercise/sports 6-7 days/week)

___ Extra active (very hard exercise/sports & physical job or 2x training)

Diet

Are you dieting? _____ If yes, are you on a physician prescribed medical diet? _____

Number of meals you eat in an average day? _____

How often do you eat out? Never ___ Less Often ___ Frequently ___

What restaurants do you frequently eat out at? _____

How often do you eat "fast foods?" Never ___ Less Often ___ Frequently ___

What time of day and on what day do you shop for groceries? _____

Rank fat intake High ___ Medium ___ Low ___

Caffeine

None ___ Coffee or Tea or Cola ___ Number of cups/cans per day _____

Alcohol

Do you drink alcohol? ____ If yes, what kind? _____

How many drinks per week? _____

Tobacco

Do you use tobacco? ____ What kind of tobacco? (Cigarettes, Chew, Pipe, Cigars?)..... _____

How much per day? _____ Number of years smoking _____

If not smoking, what year did you quit? _____

Drugs

Do you currently use recreational or street drugs? _____

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Dietary History

1. Record all weight loss attempts starting with your first diet through your most recent attempt.
2. If you have tried weight-loss medications also, include the type of diet plan you follow (low fat, 1200 calorie, etc.) while receiving the medication.

Year	How long were you on this diet?	Weight at start	Weight lost	Type of Diet/ Program	Doctor or Dietician who supervised this diet

Supervised Diets
Diet Counters
Medifast
Supervised calorie counting diet (Dietician or Nutritionist)
Overeaters Anonymous
Optifast
New Direction
Weight Watchers
Health Management Resources
Nutrisystems
T.O.P.S.
Jenny Craig
National Weight Loss

Non-Supervised Diets
Body for Life
Calorie counting
Atkins diet
Health spas
High protein
Hypnosis
Low carbohydrates
Low fat
Pritikin
Richard Simmons
Scarsdale
Stillman diet
Sugar Busters
Slim-Fast
Mayo Clinic

Weight Loss Medications
Acutrium
Acipex-P
Amphetamines
Anorex
Benzphetamine
Bontril
Dexatrim
Dexfenfluramine
Didrex
Fastin
Fenfluramine
Fen-Phen
Ionamin
Mazanor
Meridia
Obalan
Orlistat
Phendiet
Phentermine
Pentrol
Plegine
Pondimin
Prelu-2
Redux
Sanorex
Tenuate
Tepranol
Wehless
Xenical
X-Trozine

Mental Health

Is stress a major problem for you? _____ Do you feel depressed? _____

Do you have problems with eating or your appetite? _____

Women Only

First Day of last menstruation _____ Are you pregnant? _____

Are you breastfeeding? _____

Other (Check if you have/had any symptoms in the following areas and briefly explain)

___ Skin ___ Head/Neck ___ Ears ___ Nose ___ Throat ___ Lungs ___ Chest/Heart

___ Back ___ Intestinal ___ Bladder ___ Bowel ___ Circulation _____

Recent Changes: ___ Weight ___ Energy Level ___ Ability to sleep ___ Other pain/discomfort:

_____