HEALTH PLUS
PERSONAL HEALTH HISTORY

Welcome to Health Plus. Our hope is that we will be able to assist you in improving your present and future health. In order to deliver high quality and safe care, we request your answers to the following questions. All answers are confidential and will not be released to anyone without your written permission.

Name:______________________________________ Today's Date:______________
First Middle Last

Address: ____
Number and Street Apt. City State Zip

Phone: __________________ __________________ __________________
Cell Work Home

Occupation: ______________________ Job Duties: ______________________
Job Title What you actually do

Date of Birth ________________ Who do you live with: ______________________

How did you hear about Health Plus? ____

What is your email address? ____

MEDICAL HISTORY

Do you have, or have you ever had:

YES	NO	DISEASE/SYMPTOM	EXPLAIN
___	___	Addiction	
___	___	Alcoholism	
___	___	Allergy to medication	
___	___	Arrhythmias/Irregular heartbeat	
___	___	Arthritis	
___	___	Anorexia/Bulimia/Purging	
___	___	Asthma	
___	___	Cancer	
___	___	Chest Pain	
___	___	Depression	
___	___	Diabetes	
___	___	Edema/Swelling of the ankles	
___	___	Glaucoma	
___	___	Gall Stones/Gallbladder disease	
___	___	Headaches	
___	___	Heart Disease	
___	___	High blood pressure	
___	___	High cholesterol	
___	___	Kidney disease	
___	___	Liver disease	
___	___	Mental illness	
___	___	Shortness of breath	
___	___	Seizures/Epilepsy	
___	___	Sleep Apnea	
___	___	Stroke/Cerebral vascular disease	
___	___	Thyroid Problems	

Do you have any medical problems not listed above? Please List: ______________________________

____

Please list all surgeries that you have had and provide dates:

____

____

Please list all prescription and over-the counter medication that you are currently taking or have taken in the past 3 months:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________
9. ______________________________ 10. ______________________________

Do you smoke or use tobacco products? _______ How much? _______ Since what age? ______

How much alcohol do you drink? ____

How much caffeine do you consume? ____

Is there any chance that you are pregnant? _____ Are you breast feeding? ____________________

Are you planning a pregnancy in the next year? _____

If you currently exercise, what form(s) of exercise do you do and how frequently? _______________

____

Do you think you exercise enough? ____

What gets in the way of you exercising more? ____________________________________

What forms of exercise have you done in the past? _________________________________

Do you have a primary care provider? ____ When was your last physical or check up? _________

____
Name or Clinic of your PCP
____

Please list any serious medical problems that your biological relatives have had:

Mother____
Father____
Siblings____
Children____
Aunts/Uncles____
Grandparents____

Do you have any other health related information that you think we should know? _______________

____

What is your main reason for wanting to lose weight? ______________________________________

____

Why do you think you have a weight problem (genetics, overeating, lack of exercise, etc.)?

____

At what age were you first overweight? _________________

Do you feel that you overeat? ________ If so why? ____

Do you feel that you are hungry more often than you should be? ______________________________

Do you keep eating when you know you are (or should be) full? ______________________________

Do you struggle with food cravings that you can't seem to control? ___________________________

What foods do you typically crave? ____

When you overeat, do you feel that you have been "bad" ? __________________________________

Including snacks, how many times do you eat in a typical day? ______________________________

Do you skip meals frequently? __________ If so, why? _____________________________________

What do you typically eat for breakfast? ____

What do you typically eat for lunch? ____

What do you typically eat for dinner? ____

What do you typically eat for snacks? ____

What do you typically drink when you are thirsty? ____

How much water do you drink on a typical day? ____

Do you have a family history of weight problems? _______ Who ____________________________

What is your: Weight today? ______ Highest weight ever? ________ Goal weight? ______

Please list all previous weight loss diets or programs (e.g., Weight Watchers, Jenny Craig, etc.)

DATES PROGRAM RESULTS

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

Have you ever been on prescription or over-the-counter weight loss medication? _______________

DATES NAME OF MEDICATION RESULTS

1. ____

2. ____

3. ____

4. ____

If you have regained weight that you had previously lost, why do you think that was? ___________

____

What social supports do you have to assist you with your weight loss efforts? ________________

____

What do you see as the barriers that could potentially interfere with your efforts to lose weight?

____

Do you have any specific concerns or questions that you would like addressed today?

____

____

Do you feel that counseling or therapy would be a helpful part of your program? _______________

If so, do you need a referral? ______________