Vitality Weight Reduction Medical History Form

Name:_______________________________________Dob:_________________

Allergies:____

____

Do you Smoke ☐ Yes ☐ No If Yes, how much?____________________________

Alcohol ☐ Yes ☐ No If Yes, how often?___________________________________

Please list Prior Surgeries:____

____

Are you on the following medications?

☐ Zyprexa (Olanzapine),Clozaril (clozapine), Risperdal (risperidone)
☐ Prozac, paxil, zoloft, celexa,lexapro, notryptiline amytriptiline, lithium
☐ Depakote (Valparoate), Neurontin (Gabapentin), Tegretol (Carbamazepine)

☐ Glucotrol, Insulin, Actos, Avandia
☐ Prednisone, Medrol
☐ Birth Control, Oral Contraceptives, Depoprovera
☐ Benadryl, Zyrtec, Claratin, Alivert, Allegra
☐ Hytrin, Toporol, Lopressor

Do you have a personal history of:

☐ Diabetes
☐ Heart Attack
☐ Thyroid Disorder
☐ High Blood Pressure

☐ Menstrual Problems
☐ Neurologic Disorders
☐ Drug or alcohol addiction

☐ Heart Disease
☐ Kidney Disease
☐ Cancer, If yes what type?
☐ Migraines

☐ Arthritis
☐ Stroke
☐ Bulemia/Anorexia

Are you experiencing any of the following symptoms of hormonal imbalance?

☐ Mood Swings
☐ Fatigue
☐ Anxiousness
☐ Sleep Problems
☐ Heavy Menses
☐ Fibrocystic Breasts
☐ Osteoporosis

☐ Hot Flashes
☐ Headaches
☐ Joint Pain
☐ Skin Changes
☐ Irritability
☐ Ddecreased Sex Drive
☐ Hair Loss

☐ Night Sweats
☐ Depression
☐ Memory Lapse
☐ Vaginal Dryness
☐ Incontinence
☐ Breast Tenderness
☐ Decreased Muscle

Do you have a family history of:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ High Blood Pressure
- ☐ Neurologic Disorders
- ☐ Asthma
- ☐ Kidney Problems
- ☐ Heart Attack
- ☐ Cancer, Type:
- ☐ Arthritis

Is there a chance you might be pregnant? ☐ Yes ☐ No

Goal Weight_________________

Weight at 20 years of age________________ Weight one year ago________________

How often do you eat out weekly? Breakfast________Lunch_________Dinner__________

Do you wake up hungry at night? Yes NO

Are you currently under stress? Yes NO

Typical Breakfast ______________________________________ Time eaten___________

Typical Lunch ____Time eaten___________

Typical Dinner____Time eaten____________

Prior Diet Experience: ____

____

Current Exercise: ____

____

May we leave messages at your contact number? ☐ Yes ☐ No

Signature: ____ Date:_____________________