Getting started | MEDICAL HISTORY

fueling fitness

Achieving weight, health and performance goals. One step at a time.

Date:

Name:

Address:

City:

Zip:

Age: Height:

Weight (lbs): Desired weight (lbs):

Resting heart rate:

Occupation:

Marital status:

Children: ❒ Yes ❒ No

If yes: names and ages:

Day phone:

Evening phone:

Cell phone:

Fax:

E-mail:

Describe any health issues:

Do you take a multivitamin or any other supplements? ❒ Yes ❒ No

If yes, please list brand and type:

Do you take any medications? ❒ Yes ❒ No

If yes, please list:

Do you have any food allergies, intolerances or do you follow any special diet? ❒ Yes ❒ No

If yes, please describe:

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Are there foods that you will not eat? If so, please list:

_____

Do you consume caffeine: ❒ Yes ❒ No

Date of most recent physical exam: _____

(**NOTE:** If available, please supply a copy of lab values)

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Family health history:

CONDITION	MATERNAL	PATERNAL	SELF	SIBLINGS
Heart disease	❒	❒	❒	❒
Hypertension	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒
Depression	❒	❒	❒	❒
Migraine	❒	❒	❒	❒
Obesity	❒	❒	❒	❒
Stroke	❒	❒	❒	❒
Asthma	❒	❒	❒	❒
Anemia	❒	❒	❒	❒
Cancer	❒	❒	❒	❒
Cardio-vascular	❒	❒	❒	❒
Other	❒	❒	❒	❒

_____

Indicate frequency of any of following conditions (use the numbers below):

0 = NEVER **1** = ONCE EVERY 6 MONTHS **2** = ONCE A MONTH **3** = WEEKLY **4** = DAILY

_____ Sore muscles	_____ stomach cramps	_____ anxiety
_____ Joint pain	_____ stomach aches	_____ feeling cold
_____ Muscle cramps	_____ stress–job	_____ cold/flu
_____ Headaches	_____ stress–personal	_____ crave sweets
_____ Tension	_____ diarrhea	_____ insomnia
_____ Migraines	_____ fatigue	_____ depression

Females:

Are you menstruating? ❒ Yes ❒ No

Do you take birth control pills? ❒ Yes ❒ No

Describe your periods: ❒ heavy ❒ medium ❒ light

Are you menopausal? ❒ Yes ❒ No

If yes, are you experiencing:

Hot flashes: ❒ Yes ❒ No

Sleep problems: ❒ Yes ❒ No

Mood swings: ❒ Yes ❒ No

Post menopausal? ❒ Yes ❒ No

If yes, are you on HRT ❒ Yes ❒ No

Which kind:

_____

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Describe current exercise (if available, 4 weeks of exercise logs would be helpful):

What is your past exercise/athletic history:

Have you had exercise-related injuries in the past? ❒ Yes ❒ No

If yes, please describe:

Do you stretch regularly or practice yoga or meditation? ❒ Yes ❒ No

If yes, please describe:

*

I have completed this medical history form to the best of my knowledge. I understand that nutritional counseling is designed to be a health aid and is in no way meant to take the place of a doctor's care, when it is indicated. Nutritional information exchanged is intended to support and enhance my lifestyle. It is educational and therapeutic in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Signature: Date:

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