HARTSDALE MEDSPA
WEIGHT LOSS & LASER BODY CONTOURING

Medical History Form

Patient Name (last, First): Date of Birth:

Are you in good health at the present time to the best of your knowledge? Y/N

Are you under a doctor's care at the present time? Y/N

If yes, for what?

Are you taking any medications at the present time? Y/N

Name of Medication Taken for

Name of Medication Taken for

Name of Medication Taken for

Name of Medication Taken for

Do you have any allergies to any medications? Y/N

If yes, with what?

Do you have history of following Y/N

High Blood Pressure Y/N

Diabetes (what age?) Y/N

Heart Attack Y/N

Chest Pain Y/N

Swelling of Feet or Hands Y/N

Frequent Headaches Y/N

Do you take medication for headaches? Y/N

If yes, what? Y/N

Migraines

Constipation

Galucoma

Gynecologic History

Pregnancies: Number Dates

Natural Delivery or C-Section (specify)

Menstrual Cycle: Age of Onset Duration (Days)

Are they regular Y/N

Painn Associated Y/N

Last Menstrual Period Y/N

Harmone Replacement Therapy Y/N

If yes, what?

Birth Control Pills Y/N

If yes, type?

Last checkup date

Medical History Form

Any serious injuries	Y/N
Specify	Date
Specify	Date
Specify	Date

Surgeries	Y/N
Specify	Date
Specify	Date
Specify	Date

Family History

Father Age	Good Health	Y/N
Mother Age	Good Health	Y/N

Does your father, mother, sisters, or brothers suffer from any of the following

Heart Disease	Y/N
High Cholesterol	Y/N
Diabetes	Y/N
Cancer	Y/N
Obesity	

Has any blood relative had any of the following

Glaucoma	Y/N	Who
Asthma	Y/N	Who
Epilepsy	Y/N	Who
High Blood Pressure	Y/N	Who
Kidney Disease	Y/N	Who
Diabetes	Y/N	Who
Tuberculosis	Y/N	Who
Psychiatric Disorder	Y/N	Who
Heart Disease/Stroke	Y/N	Who
HIV/Hepatitis	Y/N	Who

Past Medical History (check all that apply)

Polio	Bleeding Disorder	Pneumonia
Measles	Nervous Breakdown	Malaria
Tonsilitis	Ulcers	Typhoid Fever
Jaundice	Gout	Cholera

Medical History Form

Mumps	Thyroid Disease	Cancer
Pleurisy	Anemia	Blood Transfusion
Kidneys	Heart Disease	Arthritis
Scarlet Fever	Tuberculosis	Osteoporosis
Liver Disease	Gallbladder Disorder	Others
Lung Disease	Psychiatric illness	
Whooping Cough	Drug Abuse	
Chicken Pox	Eating Disorder	
Rheumatic Fever	Alcohol abuse	

Nutrition Evaluation

Present Weight	Height	Desired Weight

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

Birth Weight	Weight at 20yrs	Weight 1 yr ago

What is the main reason for your decision to lose weight

When did you begin gaining excess weight? (If known, give reasons)

What has been your maximum lifetime weight (non-pregnant) and when

Previous diets you have followed, dates and results of weight loss

Is your spouse, fiance', or partner overweight Y/N

By how much is he/she overweight

How often do you eat out

What restaurants do you frequent

How often do you eat "fast foods"

Who plans meals	Cooks?	Shops?

Do you use a shopping list Y/N

What day of the week and time of the day do you generally shop for groceries

Food Allergies

Food dislikes

Medical History Form

Food you crave

Is there any specific time of day or month that you crave food

Do you drink coffee or tea	Y/N	How much daily?
Do you drink cola drinks	Y/N	How much daily?
Do you drink alcohol	Y/N	
What	How much	Frequency
Do you use sugar substitute	Y/N	
Do you use Butter or Margrine		
Do you awaken hungry during the night		Y/N

What do you do _____

What are your worst food habits _____

Snack Habits

What	How much	When
What	How much	When

When you are under a stressful situation at work or family related,do you tend to overeat? Y/N

If yes, explain _____

Do you think you are currently undergoing a stressful situation or an emotional upset? Y/N

If yes, explain _____

Smoking Habits (answer only one)

Never smoked cigarettes, cigars, or a pipe Y/N

Quit smoking _____ years ago and have not smoked since

Quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke

Smoke 20 cigarettes per day (1 pack)

Smoke 30 cigarettes per day (1 1/2 pack)

Smoke 40 cigarettes per day (2 pack)

Typical Breakfast

Typical Lunch

Typical Dinner

Activity Level (answer one)

Inactive no regular physical activity with sit-down job

Medical History Form

Light No organized physical activity during leisure time

Moderate Occasionally involved in activities as weekend golf, tennis, jogging, swimming, cycling

Heavy Consistent lifting, stair climbing, heavy construction, etc, or regular participation in jogging, swimming, cycling, or active sports at least three times per week

Vigorous Participation in extensive physical exercise for at least 60 minutes/session 4 times per week.

Behavior Style (answer only one)

You are always calm and easygoing

You are usually calm and easygoing

You are seldom calm and persistently driving for advancement

You are never calm and have overwhelming ambition

You are hard-driving and can never relax

Please describe your general health goals and improvements you wish to make

_____

_____

_____

_____