

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I.): _____ DOB: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Emergency Contact: _____

Email: _____

PERSONAL HEALTH HISTORY

1. To the best of your knowledge, how would you rate your health? Excellent Good Fair
Poor

2. Present Weight (lbs): Height (inches): Desired Weight:

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

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

5. Does your family support your efforts to lose weight? Yes or No

6. Are they overweight or obese? Yes or No

7. Do you suffer from any of these health conditions?

High Blood pressure	Yes	No
High Cholesterol	Yes	No
Diabetes	Yes	No
COPD	Yes	No
Asthma	Yes	No
Heart disease	Yes	No
Arthritis	Yes	No
Breast Cancer	Yes	No
PCOS	Yes	No

8. List any medical problems that other doctors have diagnosed

9. Surgeries (Year and Reason)

10. Other hospitalizations

Parent/Legal Guardian Signature (if under 18)