Robert M. Huster, M.D., PC
Metabolic / Weight Management
Medical History Form

Name ____ Age ______ Date _________

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Living w partner

Occupation ____

Employer ____

Average hours worked per week ____

Besides you, who currently lives in your home and their ages:

____

____

____

____

List any medical conditions that are currently under treatment:

____

____

____

____

List all prescription drugs you take

____

____

____

____

List all over-the-counter medications, vitamins, supplements ___________________

____

List any allergies to medications and what was your reaction

____

____

____

Do **YOU** have a history of:

High blood pressure?	Yes	No
Diabetes?	Yes	No
Heart attack, chest pain, or other heart condiditon?	Yes	No
Swelling of feet?	Yes	No
Frequent headaches?	Yes	No
Seizures?	Yes	No
Constipation?	Yes	No
Alcohol Abuse?	Yes	No
Drug Abuse?	Yes	No
Glaucoma?	Yes	No
Sleep apnea?	Yes	No
If yes, do you use CPAP?	Yes	No
Eating Disorder?	Yes	No

If yes, please list dates and diagnosis:

____

Other medical conditions - list with dates:

____

____

Serious Injuries? Yes No

List all with dates:

____

____

____

List any surgeries with dates:

____

____

____

If Female - Gyn History

Menses are ☐ regular ☐ irregular ☐Post-menopausal

Last menstrual period ____

Current method of birth control ____

Nutrition Evaluation:

Current weight _____________ pounds

Highest weight and date ___________ pounds. When ___________

Your weight loss goal ______________ pounds

When would you like to be at this weight? ________________________

Other than overall better health, do you have a specific reason to lose weight?

____

Describe previous successful weight-loss efforts and dates:

____

Dietary Habits

Do you regularly eat breakfast: Yes No

If yes, what does your breakfast usually consist of: __________________________

____

How often do you eat out? ________________ times per week.

Which restaurants do you frequent? _______________________________________

____

How often do you eat "fast foods" __________ times per week.

Who plans meals? _________________

Who cooks meals? ________________

Who grocery shops? _______________

List any food allergies or sensitivities: _______________________________________

____

List Food dislikes: ____

____

List Food(s) you crave: ____

Do you drink sugar-sweetened beverages (not diet)? Yes No

If yes, what do you drink? ____

How many per week? ☐1-5 ☐5-10 ☐10-15 ☐More than 15

Do you drink alcohol? Yes No

If yes, what do you drink? ____

How many per week? ❒1-5 ❒5-10 ❒10-15 ❒More than 15

Do you awaken and eat in the middle of the night? Yes No

Are you a stress eater? Yes No

List your worst food habit(s): ____

____

Do you currently use tobacco products of any kind? Yes No

If yes, what kind and much? ____

Activity Level - (Pick best example)

Inactive - no regular physical activity with a sitdown job? ❒

Light activity - no organized physical activity during liesure time? ❒

Moderate activity - occasionally involve in weekend activities such as weekend golf, tennis, jogging, swimming, etc. ❒

Heavy activity - consistent lifting, jogging, cycling, swimming, etc, at ❒

Vigorous activity - extensive physical exercise, 60 minutes/session, 4 ❒