Robert M. Huster, M.D., PC
Metabolic 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 _____

_____

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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:

_____

_____

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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?

_____

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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

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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 t ☐

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

Heavy activity - consistent lifting, jogging, cycling, swimmin ☐

Vigorous activity - extensive physical exercise, 60 minutes/s ☐