Health History

Name: ____ Date:__________________

Address:____

City:______________________________ State:_____________ Zip Code:______________

E-mail Address:____

Phone:____

Your answers on this form will help your consultant get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank you!

Present Height__________ Present Weight ___________ Your Goal Weight __________

Have you attempted to lose weight before? ______ Pounds lost? ______ How long it took?________

Describe previous methods of weight loss (e.g. programs, diet pills, hypnosis, etc.)

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MEDICATIONS: Please list all prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this page if you need more room. __ TAKE NO MEDICATIONS

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Do you currently have any of the following conditions? (Circle all that apply)

Cancer, Chemotherapy, Diabetes, Gallbladder Disease, Gout, Grave's Disease, Heart Condition, High Blood Pressure, Pregnant or Nursing, Taking Antibiotics, Tuberculosis, Uterine Fibroids

Do you exercise? Yes / No

I have completed this Health History Form to the best of my knowledge. I understand that my information will be held in the strictest of confidence, and no personal identifying information will be used for any reason unless I authorize the use in writing.

Printed Name / Signature / Date:____