**Weight and Health History**
**Jan Hester, MD PC**

Name: _____
DOB: ___/___/_____
Primary Care Provider: _____

Drug Allergies: _____
Current Medications/Supplements, dose/frequency: _____
_____
Medical Problems: _____
_____
Past Surgical History: _____
_____
Family History of Medical Problems: _____
_____

Tobacco: Y/N How many/day? _____
Alcohol: Y/N How much? _____
Current Employment: _____
Marital Status: (circle one) Married/ Single/ Separated/ Divorced/ Widowed/ Domestic Partnership
Children: Y/N How many? _____ Their ages: _____

WEIGHT HISTORY:
Family History of Obesity? Y/N If yes, who: _____
Age of onset of your weight problems: _____
Your weight at age 18: _____
Do you exercise? Y/N. If so, what do you do? _____
History of Anorexia/ Bulimia/ Binge-eating/ Emotional eating? (please circle)
History of diet pill use? Y/N If so, what have you used? (prescription, over the counter).
When, duration of use, weight loss response: _____
_____
Other methods for weight loss (programs, diets, surgeries). When, duration of effort, weight loss response: _____
_____

Maximum Weight: _____
Goal Weight (or size): _____
Please list typical:
- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____
- Fluids: _____