NORTHERN
Family Medicine
a department of Northern Regional Hospital

Medical History Form

Name: Last _____ First _____ M_____

Date of Birth: _____ Age _____ Sex: ____Male ____ Female

Current Medications:

Name of Medication	Strength	Directions

Any known Medication or Food Allergies? _____

YOUR present **Health Status** (*not family*)

YES	NO	
___	___	High blood pressure
___	___	Migraines?
___	___	Heart Attack?
___	___	Blood Clots?
___	___	Breast Cancer?
___	___	Ovarian Cancer?
___	___	Uterine Cancer?
___	___	Glaucoma?
___	___	Kidney Disease?
___	___	Prostate Cancer?
___	___	Asthma?

YES	NO	
___	___	Have you ever smoked?
___	___	Do you currently smoke?
___	___	Currently on birth control?
___	___	Possibility of pregnancy?
___	___	Currently breastfeeding
___	___	Thyroid Disease?
		If yes, Hypo? or Hyper? _____
___	___	Diabetes?
		If yes, Type I or Type 2? _____

What is your **Surgical History**?

_____
_____
_____

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Medical History Form (continued)

Your past **Medical History** (not Family)

	Yes	No		Yes	No
Bulimia?			Polycystic Ovarian Disease?		
Anemia?			Drug Abuse?		
Kidney Stones?			Rheumatic Fever?		
Bleeding Disorder?			Osteoporosis?		
Cancer?			ADD/ADHD?		
Anorexia?			Liver Disease?		
Seizures?			Alcohol Abuse?		
Gout?					

If you answered YES to any on previous page...please explain:

_____

_____

Please list any other information about your medical history that we may have not asked.

_____

_____

Activity Self−Assessment: ***Check One***

1. _____ **Inactive**−no regular physical activity with a sit down job.

2. _____ **Light activity**−no organized physical activity during leisure time.

3. _____ **Moderate activity**−"occasionally" involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

4. _____ **Heavy activity**−consistent lifting, stair climbing, heavy construction, etc...or "regular" participation in jogging, swimming, cycling or active sports at least 3 times per week.

5. _____ **Vigorous activity−**participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

This information will assist us in assessing your particular problem areas and establishing your medical weight loss program. Please verify that you have answered the questions in this Medical History Form truthfully and to the best of your ability.

Signature: _____ Date: _____

Witness: _____ Date: _____ Time: _____