**SCREENING: Participant’s Medical History Form**



Name: \_\_\_ DOB \_\_\_\_\_\_\_\_\_Age: \_ Sex: M F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers: E-mail address:

*Dear Participant:*

*In order to serve you the best & help you accomplish your health & wellness goal, it is very important that your health management team understands your medical, nutritional & behavioral profile thoroughly. For this purpose we ask you to fill this detail information. Please answer all the questions truthfully and to best of your knowledge & understanding. If you do not understand a question, your team members will help you.*

*This information will be provided for a consultation with a Physician with expertise in Bariatric & nutritional issues. Expert will review your information in detail. Purpose of the consultation is not to establish a diagnosis, but rather to determine your health status in order to formulate your personalized Program plan. You may be advised to have certain medical tests and / or seek medical advice based on your current health status.*

**RELATIVE CONTRA-INDICATIONS:**



If you have a history of or currently have diagnosis of any of the following conditions, you can not go on ***BaroFIT*** Program **without written permission\* of your Primary Care Physician or specialist taking care of you at present:**

|  |  |  |
| --- | --- | --- |
| **CONDITION** | **Yes** | **No** |
| Pregnant female |  |  |
| Breast feeding female |  |  |
| Heart attack, stroke, aneurysm, by-pass, stent surgery |  |  |
| History of having cardiac arrhythmia, including having pace-maker |  |  |
| History or current active cancer, including skin cancer |  |  |

**NOT ALLOWED AT ALL:**



**Sorry, if you have any of the following conditions, you *cannot* participate in *BaroFIT* :**

|  |  |  |
| --- | --- | --- |
| **CONDITION** | **Yes** | **No** |
| Do not eat any milk products i.e. Strict Vegan lifestyle |  |  |
| Parkinson’s Disease |  |  |
| Taking Lithium Therapy |  |  |
| Diagnosis or History of Congestive Heart Failure (CHF) |  |  |
| Severe Kidney Damage / Disease |  |  |
| Severe Liver Damage / Disease |  |  |

***Thank you in advance for your time and patience in completing the following form.***

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***PRESENT MEDICAL STATUS***

1. To the best of your knowledge, are you in good health at the present time? Yes No

Explain a “No” answer: What is wrong with you?

1. Are you under a doctor’s care at the present time? Yes No

|  |  |
| --- | --- |
| If yes, for what conditions? |  |
| Name of doctor? |  |
| Address of Doctor? |  |
| Phone of Doctor? |  |

1. Are you taking any ***medications*** at the present time? Yes No
2. Prescription Drugs: List all the medications your doctor has prescribed for you.

|  |  |  |  |
| --- | --- | --- | --- |
| Drug Name | Dosage | How many times a day? | Since when? For What Medical Condition? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Over-the-Counter/ non-prescription herbal medications, vitamins, supplements etc: List all

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Product Name | Dosage | How many times a day? | Since when? | For What Medical Condition? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Any **allergies** to any medications or Food products? Please list: Yes No

|  |  |  |
| --- | --- | --- |
| Allergic to: Name | Since when? | What reactions do you get? |
|  |  |  |
|  |  |  |
|  |  |  |

1. Current Medical conditions: Do you currently have any of the following conditions?

|  |  |  |
| --- | --- | --- |
| **High Blood Pressure** | Yes | No |
| **Diabetes**  At what age: | Yes | No |
| **Heart Attack or Chest Pain or other heart condition** |  |  |
| **Swelling of Feet** |  |  |
| Frequent **Headaches**?  **Migraines**? Yes No Medications for Headaches: Yes No | Yes | No |
| **Constipation** (difficulty in bowel movements)? | Yes | No |
| **Glaucoma -** increased pressure in eyes | Yes | No |
| **Sleep Apnea** | Yes | No |

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**6. (For Females only) Gynecologic History:**

Pregnancies: Number: Dates:

Natural Delivery or C-Section (specify):

Menstrual: Onset:

Duration:

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period:

Hormone Replacement Therapy: Yes No

What:

Birth Control Pills: Yes No

Type:

Last Check Up:

***YOUR PAST MEDICAL HISTORY*** (check all that apply)

Polio Measles Tonsillitis

Jaundice Mumps Pleurisy

Kidneys Scarlet Fever Liver Disease

Lung Disease ` Whooping Cough Chicken Pox

Rheumatic Fever Bleeding Disorder Nervous Breakdown

Ulcers Gout Thyroid Disease

Anemia Heart Valve Disorder Heart Disease

Tuberculosis Gallbladder Disorder Psychiatric Illness

Drug Abuse Eating Disorder Alcohol Abuse

Pneumonia Malaria Typhoid Fever

Cholera Cancer Blood Transfusion

Arthritis Osteoporosis Other:

**Serious Injuries**: Yes No

|  |  |
| --- | --- |
| Specify (list all) | Date |
|  |  |
|  |  |

**Any Surgery:** Yes No

|  |  |
| --- | --- |
| Specify: (List all) | Date |
|  |  |
|  |  |

***FAMILY HISTORY***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | AGE | HEALTH | Diseases | Overweight? | Cause of Death |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Brothers |  |  |  |  |  |
| Sisters |  |  |  |  |  |

Has any blood relative ever had any of the following?

Glaucoma Yes No Who:

Asthma Yes No Who:

Epilepsy Yes No Who:

High Blood Pressure Yes No Who:

Kidney Disease Yes No Who:

Diabetes Yes No Who:

Psychiatric Disorder Yes No Who:

Heart Disease/Stroke Yes No Who:

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***YOUR NUTRITIONAL & SOCIAL EVALUATION***

1. Height (no shoes): Present Weight: Desired Weight:
2. In what time frame would you like to be at your desired weight?
3. Birth Weight: Weight at 20 years of age: Weight one year ago:
4. What has been your maximum lifetime weight (non-pregnant) and when?
5. When did you begin gaining excess weight? (Give reasons, if known):

6. What is the main reason for your decision to lose weight? Mark all that applies.

|  |  |
| --- | --- |
| Look Better | Getting married in near future |
| Feel better | Will be attending social function |
| Improve my health conditions | My partner /parent /friend want me to lose weight |
| Other: | Other: |

7. Previous diets you have followed: Yes No

|  |  |  |
| --- | --- | --- |
| Name of the diet | Dates | Wt Lose Result? |
|  |  |  |
|  |  |  |

1. Members in your family living with you:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spouse/Partner/roommate | Overweight | Normal wt. | In Law -1 | Overweight | Normal wt. |
| Child -1 | Overweight | Normal wt. | In Law-2 | Overweight | Normal wt. |
| Child -2 | Overweight | Normal wt. | Other | Overweight | Normal wt. |

**9**. Please fill the following table

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Food you eat?*** | **Yes** | **No** | ***Food you eat?*** | **Yes** | | **No** |
| Non-vegetarian |  |  | Vegetarian |  |  | |
| Fish |  |  | Milk Products |  |  | |
| Sea Food |  |  | Onion |  |  | |
| Goat |  |  | Eggs |  |  | |
| Pork |  |  | Beef |  |  | |

10. How often do you eat out?

11. What restaurants do you frequent? Indian Italian Chinese Fast Food Chain Other\_\_\_\_\_\_\_\_\_\_\_

12. How often do you eat “fast foods?”

13. Who plans meals? Cooks? Shops?

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you usually shop for groceries?

16. Food allergies:

17. Food dislikes:

18. Food(s) you crave: □ Sweet foods □ Salty foods □ Fatty foods

19. Any specific time of the day or month do you crave food?

20. Do you drink coffee or tea? Yes No How much daily?

**20w. Do you drink Water?** Yes No How much daily? \_\_\_\_\_\_\_\_

21. Do you drink cola drinks? Yes No How much daily?

22. Do you drink alcohol? Yes No

What? \_\_\_\_\_\_\_ How much daily? Weekly?

23. Do you use sugar substitute? Butter Substitute? Margarine?

24. Do you awaken hungry during the night? Yes No

What do you do?

25. What are your worst food habits?

26. Snack Habits:

What? How much? When?

\_\_\_\_\_\_\_

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27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

29. Smoking / Tobacco Habits: **(answer only one)**

You have never smoked cigarettes, cigars or a pipe. Or have consumed Tobacco in any form like Gutka etc

You quit smoking years ago and have not smoked since.

You have quit smoking cigarettes at least one year ago.

You smoke less than 20 cigarettes per day (1 pack). How many Cigarettes\_\_\_\_\_or How many Gutka\_\_\_\_

You smoke more than 20 cigarettes per day. How many\_\_\_\_\_\_\_

30. Typical Breakfast Typical Lunch Typical Dinner

Time eaten: Time eaten: Time eaten:

Where: Where: Where:

With whom: ­ With whom: With whom:

31. Describe your usual energy level: Encircle what is applicable.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Morning | Excellent | Good | Medium/Just OK | Low | Very Low |
| Noon - 2 PM | Excellent | Good | Medium/Just OK | Low | Very Low |
| Afternoon 4-6 PM | Excellent | Good | Medium/Just OK | Low | Very Low |
| Night 8-10 PM | Excellent | Good | Medium/Just OK | Low | Very Low |

32. Activity Level: **(answer only one)**

Inactive⎯no regular physical activity with a sit-down job.

Light activity⎯no organized physical activity during leisure time.

Moderate activity⎯occasionally involved in activities such as weekend golf, tennis, jogging,

swimming or cycling.

\_\_\_\_ Heavy activity⎯consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..

Vigorous activity⎯participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: **(answer only one)**

You are always calm and easygoing.

You are usually calm and easygoing.

You are sometimes calm with frequent impatience.

You are seldom calm and persistently driving for advancement.

You are never calm and have overwhelming ambition.

You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make:

35. How motivated are you in accomplishing your heath & beauty Goals: Encircle one -

5 4 3 2 1

**A lot motivated motivated Do not know Not motivated not motivated at all**

Signature: Date:

***The signatory Participant hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the BaroFIT Program.***

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