Ageless Solutions
Weight Loss • Hormone Therapy • Aesthetics

Name: _____ Date of Birth: (_ _ / _ _ / _ _ _ _)

MEDICAL HISTORY

Medications (please include over the counter and birth control): _____

_____

_____

Weight loss medications tried/taken in the past: _____

_____

Allergies: _____ Could you be pregnant? ☐ Yes ☐ No

Illnesses: ☐ High Blood Pressure ☐ Diabetes ☐ GERD ☐ Asthma

☐ Anxiety ☐ Depression ☐ High Cholesterol ☐ Thyroid ☐ Migraine

☐ Other: _____

Surgeries: _____

Current Symptoms: _____

Smoking History: ☐ None ☐ Past ☐ Present: Packs per day _____ How many years_____

WEIGHT HISTORY

Motivation for weight loss: ☐ Appearance ☐ Health ☐ Fatigue

☐ Other: _____

What diets/methods have you tried? _____

Is your spouse/partner overweight? ☐ Yes ☐ No What was your weight one year ago? _____

Symptoms due to your present weight: _____

How much do you want to lose? _____ What is your goal weight? _____

Reasons for being overweight (check all that apply): ☐ Snacking ☐ Binge eating ☐ Pregnancy ☐ Sweets

☐ Eating due to boredom ☐ Eating due to depression/anxiety ☐ Alcohol ☐ Lack of exercise

☐ Other: _____

DIETARY HISTORY

Usual 8 oz. servings of beverages per day: Sweetened tea: _____ Fruit Juice: _____ Milk: _____

Soda: _____ Diet Soda: _____ Water: _____ Alcohol: _____ Coffee: _____

Other/details: _____

Usual number and time of meals each day: _____

Usual number of times per week you eat in a restaurant or have fast food: _____

Usual amount of snacks and what type consumed per day: _____

EXERCISE HISTORY

List usual type and duration of exercise you perform each week: _____

_____

Christopher B. Cave M.D. _____