

Name: Date of I	Birth: ( / /)
MEDICAL HISTORY Medications (please include over the counter and birth control):	
Weight loss medications tried/taken in the past:	
Allergies: Could you	
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:	☐ Fatigue
□ Other:	
What diets/methods have you tried?	
	ght one year ago?
Symptoms due to your present weight:	
	l weight? ating
	_
Eating due to boredom Eating due to depression/anxiety	Lack of exercise
Other:	
DIETARY HISTORY	
Usual 8 oz. servings of beverages per day: Sweetened tea: Fruit Juice	
Soda:        Mater:        Alcohol:          Other/details:         Mater:	Coffee:
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.