

Weight Management Medical Questionnaire

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Have you been diagnosed with any of the following health problems:

- Diabetes
- High blood pressure
- Hyperthyroidism
- Seizure disorder
- Severe anxiety
- Glaucoma
- Heart disease
- Sleep apnea
- Arthritis
- Any other health problems _____

Any Family History of serious health problems? What type(s)?

Are you currently taking any medications, including any over the counter supplements? (if so, please list)

Are you allergic to any medications? If so, please list below with type of reaction.

Have you had any surgeries? If so, please list below.

Are you pregnant or nursing?

What are you using for contraception?

Have you previously participated in any weight loss program(s)? Please list below with dates of participation.