



# Weight and Body Solutions Anti-Aging Program

Name: \_\_\_\_\_ Date \_\_\_\_\_

**Family History:**

(If a blood relative has suffered the following, please indicate the relationship)

Heart Attack		Arthritis		Stroke	
Cancer		Diabetes		Epilepsy	
Hypertension		Obesity		Glaucoma	
Other					

**Have you ever been hospitalized? If yes, when and why?**

Year	Illness or Operation

**Medications:**

(Please list the medications you are currently taking, and as needed.)

Medication	Dosage	How Often	Reason

**Allergies:**

(Please list any medications you are allergic to and reactions.)

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**Current Medical Diagnosis:**

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**Current and past medical or surgical problems:**

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**Current Medical History:**

Yes	No		Yes	No		Yes	No	
		Ear Infections			Dizzy Spells			Drug Abuse
		Nose Bleeds			Hypertension			Hemorrhoids
		Loss of hearing			Heart Murmur			Frequent urination
		Bad vision			Palpitations			Hernia
		Glaucoma			Sinus trouble			Gall Bladder
		Ringing in ears			Swollen ankles			Kidney disease
		Irregular pulse			Fainting spells			Sudden weight loss
		Sore throat			Chest pain			Fatigue
		Allergies			Headaches			Anemia
		Hoarseness			Stroke			Cancer
		Pneumonia			Indigestion			diabetes
		Bronchitis			Stomach ulcers			Loss of appetite
		Asthma			Diarrhea			Convulsions
		Short of breath			Alcohol abuse			Mumps or measles
		Thyroid disease			Joint pain			Numb arm/leg
		Back pain			Nervousness			Bloody/tarry stools
		Rashes			Depression			Chicken pox
		Insomnia			Moodiness			Broken bones
		Memory loss			Phobias			Polio
		Constipation			Mental illness			Tuberculosis