



**Please Print**

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Gender (please circle one):  Male  Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Is it alright to call you at the numbers listed?  Y  N

E-Mail for appointment reminders: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Where do you work/Occupation? \_\_\_\_\_

Spouse or Parent or Next of Kin:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you today / How did you hear about us? \_\_\_\_\_

How old were you when you started gaining excessive weight? \_\_\_\_\_

1. Are you aware of any medical reasons for the weight gain?  Y  N If yes please Explain: \_\_\_\_\_

2. Is your weight now stable?  Y  N Are you continuing to gain weight?  Y  N

3. What prior attempts have you made to lose the weight? \_\_\_\_\_

What were the results? \_\_\_\_\_

4. What do you think will be the benefits of your weight loss? \_\_\_\_\_

5. **Current weight:** \_\_\_\_\_ **Goal weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

Are you taking any kind of medications, herbal therapies, non-prescription drugs, etc?  Y  N

If yes, list: \_\_\_\_\_

Do you have allergies to any medications?  Y  N If so, what? \_\_\_\_\_

Have you ever had an adverse reaction to any medicine?  Y  N If so, describe: \_\_\_\_\_

**Any history of the following:** Heart disease: Hypertension (high blood pressure), Cardiovascular disease (hear or blood vessel)?

Y  N If so, describe: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

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



**Any history of the following continued:**

Pulmonary disease (lung) or asthma? Y N \_\_\_\_\_

Diabetes? Y N \_\_\_\_\_

Hypoglycemia? Y N \_\_\_\_\_

Thyroid, Adrenal or PCOS problems? Y N \_\_\_\_\_

Migraines or Seizures? Y N \_\_\_\_\_

GI, Liver, Gallbladder problems? Y N \_\_\_\_\_

Kidney or Bladder problems? Y N \_\_\_\_\_

HTN / CVA problems? Y N \_\_\_\_\_

Orthopedic problems or surgeries? Y N \_\_\_\_\_

Have you even had problems with extreme nervousness, anxiety or panic attacks? Y N \_\_\_\_\_

Have you ever had any weight loss surgery (liposuction, gastric banding / stapling, intestinal bypass, etc)? Y N \_\_\_\_\_

**Have you ever taken, or are currently taking any of the following medications? (Circle)**

- |          |            |            |             |         |              |
|----------|------------|------------|-------------|---------|--------------|
| Adipex   | Bontril    | Diet Pills | Meridia     | Tenuate | Ephedra      |
| Avelox   | Calcitriol | Effexor    | Mirapex     | Vospire | Phenmetrazin |
| Avert    | Dexidrene  | Ionamin    | Noraxin     | Xenical | Zyprexa      |
| Belamine | Didrex     | Lamictal   | Phentermine |         |              |

Do you take, Ritalin, Adderall, or any other stimulant therapies? Y N \_\_\_\_\_

Any MAOI, CNS Stimulants, Asthma medications or inhalers? Y N \_\_\_\_\_

Methylxanthine intake (caffeine)? Y N amount \_\_\_\_\_

Other Surgeries? Y N \_\_\_\_\_

Date of last physical: \_\_\_\_\_

**INTERNAL USE BELOW THIS POINT**

Physicians Notes: \_\_\_\_\_

Physical Exam (if abnormal, describe) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Starting Weight: \_\_\_\_\_ Goal: \_\_\_\_\_ BMI: \_\_\_\_\_

Impression: EKG \_\_\_\_\_ BP \_\_\_\_\_

Plan: B12/MIC  
Labs: CBC, CMP, Lipid, TSH, T4

\_\_\_\_\_ Medical Staff \_\_\_\_\_ MD