Weight Loss Evaluation Paperwork

Please complete this form to the best of your ability. If you need help our receptionist will gladly assist you!

Today's Date:____________________

Legal Name : ______________________________ Date of Birth: ____________ Age: ________

Preferred Name: ______________________________ Sex: ▢ Female ▢ Male

Race: ▢ White ▢ African American ▢ Hispanic ▢ Other: ______________________________

Address: ____

City: ________________________ State: __________________ ZIP: ________________

Cell Phone: ______________________________ Home Phone: ____________________

Social Security Number: ______________________ Height: __________ Weight: __________

Email: ____

Employer: ____________________ Occupation: __________________ Phone: __________

Emergency Contact: __________________ Relation: ______________ Phone: __________

Do you give us permission to contact this person in the event of an emergency? ▢ Yes ▢ No

How did you hear about our office? ____

Primary Care Physician: ___________________________ Phone: ____________________

Address: ____

City: __________________ State: ______ Zip: ______________

Allergies

▢ Penicillin ▢ Morphine ▢ Dye Allergies ▢ Codeine

▢ Aspirin ▢ Nitrate Allergy ▢ Seasonal (Pollen) ▢ Sulfa Drug

▢ Food Allergies ▢ Other: ____

Please describe allergic reaction you experienced and when it occurred: __________________

____

____

Medical Conditions and Diseases

Please check all personal history that applies to you:

▢ Diabetes ▢ Osteoporosis ▢ High Blood Pressure ▢ High Cholesterol

▢ Heart Disease ▢ Cancer ▢ Kidney Disease ▢ Liver Disease

▢ Thyroid Disease ▢ Anemia ▢ Smoker ▢ Fibromyalgia

- ▢ Nausea/Vomiting ▢ Acid Reflux ▢ Diarrhea ▢ Constipation
- ▢ Ulcers ▢ IBS ▢ Diverticulitis ▢ Crohns/IBD
- ▢ PCOS ▢ Chronic Fatigue ▢ Currently Pregnant ▢ Birth Control

Other (Please List): ______________________________

Family Medical History (Please List): ______________________________

____

____

Current prescription medications, vitamins, and supplements(including nutritional/protein supplements) you are presently taking (Please list all including OTC, herbs, ect): ______________________________

____

____

____

Diet and Lifestyle History

Roughly how many ounces of water do you drink daily: ______________________________

How many meals do you usually eat per day? _________ Do you skip meals? ▢ Yes ▢ No

Do you eat out? ▢ Yes ▢ No Are you a binge eater: ▢ Yes ▢ No

Have you ever had bulimia or anorexia disorder? ▢ Yes ▢ No

Do you consider yourself: ▢ a structured eater ▢ a haphazard eater

Please list food cravings: ______________________________

Are you currently participating in any specific diet? ▢ Yes ▢ No If yes, Please explain: ______________

____

Please list diets/medications you have used for weight loss in the past: ______________________________

____

Do you exercise? ▢ Yes ▢ No If yes, how often and what types of exercises: ______________________

____

Is your job activity primarily: ▢ Sedentary ▢ Light ▢ Moderate ▢ Heavy

Do you use:

Alcohol ▢ Yes ▢ No How many drinks and how often? ______________________________

Tobacco ▢ Yes ▢ No How many and how often? ______________________________

Caffeine ▢ Yes ▢ No How much and how often? ______________________________

Patient Questionnaire

How much weight are you wanting to lose? ______________________________

Please list any symptoms you are experiencing:

- ▢ Stress ▢ Sudden Weight Gain ▢ Sudden Weight Loss ▢ Insomnia

▢ Lack of energy	▢ Night Blindness	▢ Depression	▢ Diarrhea
▢ Dry skin	▢ Decreased appetite	▢ Fatigue	▢ Nosebleeds
▢Cold hands/feet	▢ Muscle Pain	▢ Chronic Pain	▢ Constipation
▢ Fluid retention	▢ Tingling fingers/toes	▢ Numbness	▢ Memory Loss
▢ Trouble Breathing	▢ Reoccuring Infections	▢ Light Sensitivity	▢ Nervousness
▢ Decreased Sex Drive	▢ Brittle Nails	▢ Hair loss	▢ Headache
▢ Nausea/Vomiting	▢ Skin Rashes	▢ Irritability	▢ Mood
▢ Increased grey hair	▢ Confusion	▢ Dizziness/lightheadedness	▢ Cramps
▢ Decreased alertness	▢ Stiff Muscles	▢ Altered taste/smell	▢ Gingivitis
▢ Shortness of breath	▢ Increased bleeding	▢ Altered taste/smell	▢ Easy bruising

Consultation for Medical Weight Loss Services

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for medical weight loss.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

Patient Name(Print): ______________________________

Patient Signature(X): ______________________________ **Date:** ______________

I have been offered and understand the **Patient Health Information Consent Form.**

I have been offered and agree to the **Missed Appointment Policy** and the **$50 fee** associated.

Patient Signature(X): ______________________________ **Date:** ____________