



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(required): _____

****Email is used for secure patient portal communication, online scheduling, and electronic statements.***

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Smoker | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> IBS | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Crohns/IBD |
| <input type="checkbox"/> PCOS | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> 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

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:

- | | | | |
|---------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sudden Weight Gain | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Insomnia |
|---------------------------------|---|---|-----------------------------------|

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

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 acknowledge and agree to the **Patient Health Information Consent Form**.*

I acknowledge and agree to the **Missed Appointment Policy** including the **\$50** missed appointment fee.*

**Policies are available on the clipboard for review.*

Patient/Parent/Guardian Signature(X): _____ **Date:** _____