



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 Assigned at Birth: ☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____

*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: _____

May we contact your doctor with our findings? ☐ Yes ☐ No

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 been diagnosed with an eating disorder ? ☐ Yes ☐ No If yes, explain: _____

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? _____

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 | ☐ Reoccurring 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 | ☐ Easy bruising | |
| ☐ Other: _____ | | | |

PHI/MISSED APPOINTMENT POLICY

I acknowledge and agree to the **Patient Health Information Consent Form**, and I confirm that all of my questions have been answered.*

I acknowledge and agree to the **Missed Appointment Policy**, including the up to \$75 missed appointment fee.*

**Policies are available on the clipboard or upon request at any time for review.*

Patient Signature(X): _____ **Date:** _____

CONSULTATION FOR MEDICAL WEIGHT LOSS SERVICES

I understand that my initial consultation is complimentary and is intended to determine whether I may be a candidate for the medical weight loss program offered at this office.

I understand that the only costs I may incur during the initial consultation process are for screening tests recommended by the Doctor that I voluntarily elect to undergo. Any applicable costs will be explained to me before I proceed.

I understand that following the consultation, I may not be accepted into the medical weight loss program, or additional testing may be recommended before proceeding.

Regardless of whether I am accepted into the program, I may request a copy of any and all medical records.

I agree to complete all required paperwork fully and truthfully to the best of my knowledge.

I understand that I am encouraged to communicate with my other healthcare providers regarding all aspects of my healthcare, including any care I receive at this office.

By signing below, I acknowledge that I have read and understood this information and agree to the terms of the complimentary medical weight loss consultation.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____