

Medical Weight Loss Center

New Patient Information

Date: ____/____/____

Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Age _____ Sex: M F

Social Security # _____ Drivers License# _____

Marital Status (Circle One): Single Married Divorced Separated Widowed Other

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Place of Employment _____

Occupation (Job Title): _____ Work Phone _____

Personal Physician's Name: _____ Specialty _____

Person to contact in case of emergency: _____

Phone# _____ Relationship to you: _____

How did you hear about us? (CIRCLE ONE): Yellow Pages Newspaper Website Patient Friend TV Radio Other _____

May we call you at home to verify your appointments? Yes No If No, please provide a contact phone # _____

Signature: _____ Date: ____/____/____

Email Address (Optional): _____

Please note: We do not participate in any insurance programs. We do not file or fill out insurance forms. If, in the future, you need a letter regarding your participation in this program, there will be a fee required. We accept cash, MasterCard/Visa and personal checks with proper photo ID. All fees are paid at the time of each visit.

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The information you provide is extremely important. Please respond to each item, and be as complete and accurate as possible.

Medical History

List ALL medications you take, INCLUDING over-the-counter vitamins, herbs, etc:

ALLERGIES: (Medications and Food): _____

Circle all of the following that you have or have had in the past:

Heart murmur Hypertension Diabetes Asthma Migraine Seizures Arthritis Gout Glaucoma
Depression Anxiety Panic Insomnia Irritable Colon Gall Bladder Disease Hepatitis Anemia
Thyroid Problems Cancer Eating Disorder Drug or Alcohol Addiction/Dependence

Circle any of the following symptoms that you have:

Fatigue Shortness of Breath Chest Pain Rapid Pulse Pounding Heart Cough Wheeze
Itchy Eyes Skin Rash Fluid Retention Swollen Ankles/Legs Indigestion Nausea Diarrhea
Constipation Unusual Thirst Frequent Urination Get Cold Easily Night Sweats Snoring
Joint Pain Back Pain Chronic Daily Pain

Do you smoke? Y N Quit. **Do you drink alcohol?** Y N If Yes, how much and how often? _____

List ALL surgery you have had (include dates): _____

Females: Number of Pregnancies: _____ Deliveries: _____ Ages of your children: _____

Weight gain with each pregnancy: 1st _____ lbs. 2nd _____ lbs. 3rd _____ lbs. 4th _____ lbs. 5th _____ lbs. 6th _____ lbs.

Did you have diabetes or Hypertension during pregnancy? Y N _____

Date of Last Menstrual Cycle: _____ Menstrual problems? Y N _____

Family History:

Mother's age _____ Health problems: _____

If deceased, age at death _____. Cause of death _____

Father's age _____ Health problems: _____

If deceased, age at death _____. Cause of death _____

How many **brothers** do you have? _____. Health problems, if known _____

How many **sisters** do you have? _____. Health problems, if known _____

Are any immediate family members overweight? Y N _____

Any heart disease, stroke, diabetes, cancer, or kidney disease in immediate family members? Y N

Please add anything else you believe is important: _____

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Weight Control Questionnaire

When did you begin gaining weight? (Circle One) Childhood High School College Marriage
After Pregnancy Employment Change During a Stressful Time Other _____
How long have you been overweight? 1 year or less 2-3 years 3-4 years >5 years _____
What is your lowest weight in the last 5 years? _____. What is your highest weight in last 5 years? _____
What is your current goal weight? _____. What is your dream weight? _____

What do you think the reason is for you being overweight? Frequently Overeat Bingeing Lack of activity
Heredity Other (explain) _____
How many regular meals do you eat a day? _____. How many times a day do you snack? _____. List things
you snack on: _____ How many times a week do you eat out? _____
Estimate the number of times a week you stop for fast food: _____

Do you ever eat a large quantity of food over a short period of time past the point of being hungry? Y N
If yes, do you feel out of control at the time? Y N. _____

How many SERIOUS attempts have you made at dieting? _____. How long have you been able to stick to
a diet? <1 month 1-2 months 2-3 months 3-4 months 4-5 months >6 months.

Why have you dropped out of diets? Boredom Burnout Hunger Stress Lack of Support
Not Ready Too Expensive Inconvenient _____

What weight reduction methods have you tried? Wt Watchers Other Diet Centers Atkins South Beach
Other Diet Books Physician Appetite Control Medication Do it yourself Other: _____

If you have taken appetite control medication, did you have any unpleasant side effects? Y N

Have you used laxatives, diuretics, or induced vomiting to lose weight? Y N _____
Did you take Phen-Fen combination medication? Y N _____

What specific difficulties do you have while dieting? _____

Why do you want to lose weight at this time? Appearance Self-Esteem Health To Please Another
Promote Social Activity Special Occasion Coming Up Other _____
How important is it to lose weight now on a scale of 1-10 ? (10 means extremely important) _____

Are you under a physician's care? Y N For what? _____
Have you been advised by your physician to lose weight? Y N _____
Do you have any physical or medical problems associated with your weight? Y N _____
Do you currently participate in any structured activity/exercise? Y N _____
What exercise and how often? _____

The information I have provided is true and correct to the best of my belief:

Patient Signature: _____ **Date:** _____

