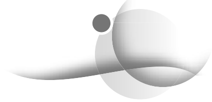


Please Print

PERSONAL INFORMATION

Name: ____________________

Date of birth: __________ 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 **Circle best number to reach you on.**

E-Mail for appointment reminders: ____________________

Primary Care Physician: ____________________

____

Date of Last Physical: ____________________

Where do you work/Occupation? ____________________

____

Spouse / Significant Other 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. If 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: __________
6. Are you taking any kind of **medications**, **herbal therapies**, **non-prescription drugs**, etc**?** **Y** **N**

If yes list: ____________________

7. **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: __________

____

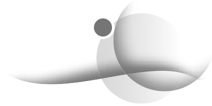
8. Any history of the following: Heart Disease, Cardiovascular disease (heart or blood vessel), Stroke? **Y** **N** If so, describe:

____

____

Signature: ____________________ **Date:** __________

Name: ____________________



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** ____________________

Hypertension / High Blood Pressure? **Y** **N** ____________________

Orthopedic problems or surgeries? **Y** **N** ____________________

Have you ever 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**

Other Surgeries? **Y** **N** ____________________

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

Adipex	Belviq	Didrex	Lamictal	Phentermine	Xenical
Avelox	Bontril	Diet Pills	Meridia	Qsymia	Ephedra
Avert	Cafcitt	Effexor	Mirapex	Tenuate	Phenmetrazin
Belamine	Dexidrene	Ionamin	Noroxim	Vosplre	Zyprexa

10. Do you take Ritalin, Adderall, or any other stimulant therapies? **Y** **N** ____________________

11. Do you take any of these MAOI's? Isocarboxazid (Marplan) / Phenelzine (Nardil) / Selegiline (Emsam) / Tranylcypromine (Parnate) **Y** **N** ____________________

12. Daily Caffeine Intake? **Y** **N** Amount: ____________________

Signature: ____________________ **Date:** ____________________

INTERNAL USE BELOW THIS POINT

BMI: ________ or Body Fat: ________% Other ____________________

BP: ________ Pulse: ________

Age: ________ Height: ________ Starting Weight: ________ Goal: ________ BMI: ________

Impression: EKG ____________________

Diagnosis: Overweight / Obese / Morbidly Obese / Localized Adiposity / Cosmetic Weight Loss

Labs: CBC, CMP, Lipid, TSH, T4

Side Effects Explained: **Y** **N**

Plan: B12 / MIC **Y** **N** Also approved for B6 / B12 / MIC **Y** **N**

Start PHEN D or AMINO

Physicians Notes: ____________________

Physicians Exam (if abnormal, describe): ____________________

____________________ Medical Staff ____________________ MD