Welcome

Patient Information

Date_____

Name_____

DOB_____AGE_____

Address_____

City_____

State_____Zip_____

Telephone (H)_____

(C)_____

Email_____

Occupation_____

Sex: Male_____ Female_____

How did you hear about us?

_____

List any allergies to medication / food:

_____

Have you ever taken prescription weight loss medication? Y_____ N_____

If yes, list medication:

_____

Would you like to be added to our email list in order to receive coupons and discounts? Y / N

HEALTH HISTORY: PLEASE CHECK ANY AND ALL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

____HEART DISEASE
____SLEEP APNEA
____HEART ATTACK
____EATING DISORDER
____STROKE
____HEART MURMUR
____SUBSTANCE ABUSE
____DEPRESSION
____HEART SURGERY
____PSYCHOSIS
____HYPERTENSION
____RADIP HEART RATE (SVT)
____ELEVATED TRIGLYCERIDES
____DIABETES
____SEIZURE
____THYROID DISEASE
____RENAL DISEASE
____GLAUCOMA
____PCOS
____TUBAL LIGATION/
____ HYSTERECTOMY
____ABLATION

HEALTH HABITS:

Do you drink caffeine? Y/ N
Do you use tobacco products? Y/ N
Do you drink alcohol? Y/ N
Do you take vitamins? Y/ N
Do you have prolonged sitting at work? Y/ N
Are you under a lot of stress? Y/ N