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 the best number to reach you.

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 weight gain? **Y** **N** if yes please explain:____
   ____
2. Is your weight now stable? **Y** **N** Are you continuing to gain weight? **Y** **N**
3. What prior attempts have you made to lose weight?
   ____
   ____
   What were results?____
4. What do you think will be benefits of your weight loss?
   ____
   ____
5. Current weight: _____________________ Goal weight:________________________________
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 Diseases, 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	Xencial
Avelox	Bontril	Diet Pills	Meridia	Qsymia	Ephedra
Avert	cafcitt	Effexor	Mirapex	Tenuate	Phenmetrazin
Belamine	Dexidrene	Lonamin	Noroxim	Vospire	Zyprexa

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

    ____

11. Do you take any of these MAOI's? Isocarboxazid (Mar plan) / 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