WEIGHT LOSS EVALUATION AND HEALTH HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

Sex ☐ M ☐ F Age _____ Birth date _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Home Phone _____ Work _____

Cell _____ Ext _____

Best time and place to reach you _____

Email Address _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birth date _____ SS# _____

Spouse's Employer _____

HEALTH HISTORY

Date of Last Physical Exam _____

Current Physician _____

FEMALES ONLY

Are you pregnant? ☐ Yes ☐ No Due Date _____

Are trying to get pregnant? ☐ Yes ☐ No

Last Menstrual Period _____

Vitamins/Herbs/Minerals _____

Allergies _____

_____

Medications _____

_____

_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home _____ Work _____

Family Health History

		Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	High Cholesterol	Osteoporosis	Thyroid	Unknown
Mother :												
Father :												
No. of Sisters :	_____											
No. of Brothers :	_____											
No. of Children :	_____											

Social History

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Standing :							
Sit at a Desk :							
Work on a Computer :							
Work on a Phone :							
Moderate/Heavy labor :							
Stay at home :							
Deliver packages :							
Tobacco/Smoke :							
Alcoholic beverages :							
Caffeine :							
Exercise :							

Conditions (Please check next to those you have had or currently have.)

	ADHD		Constipation		Heart murmur		Paralysis
	Alcohol/drug addiction		Depression/anxiety		Hemorrhoids		Pneumonia
	Anemia		Diabetes		Hepatitis		Polio
	Arrhythmia		Digestive Disorders		High Blood pressure		Prostate problems
	Arthritis		Dizziness		High cholesterol		Reflux/ulcers
	Asthma		Eating disorder		HIV/AIDS		Rheumatic fever
	Backaches		Emphysema		Joint/back pain		Seizures/epilepsy
	Bleeding disorder		Epilepsy		Kidney infections		Sexual dysfunction
	Blood clots		Fatigue		Kidney stones		Sickle cell
	Blood transfusions		Female Health Chal-		Liver disease/problems		Sinus Trouble
	Blurred Vision		Fibromyalgia		Lung disease		Stress/Tension
	Bowel Problems		Gallbladder disease		Menstrual Cramps		Stroke
	Broken bones		Genital Herpes		Mental disorder		Suicidal tendencies
	Cancer		Glaucoma		Migraines		Thyroid disease
	Carpal Tunnel		Gluten Intolerance		Neck Pain		Tuberculosis
	Cataracts		Gout		Nervousness		Tumors
	Chickenpox		Headaches		Night Sweats		Urine discoloration
	Colitis		Hearing Loss		Osteoporosis		Vertigo
	Collagen vascular	Other:_____					

Questions

Do you have a specific incentive to lose weight? Please list here.

_____

_____

Have you tried other programs to lose weight in the past? If so, which one(s)?

_____

_____

In your opinion what has been your biggest challenge in getting to or maintaining your goal weight?

_____

Compliance & Responsibility

I, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions.

PRIVACY PRACTICES

_____ _____ _____

Responsible Party Signature | Relationship to Patient | Date