VALLEY MEDICAL WEIGHT CONTROL

Name: ____
Address: ____
City/State: ___________________________________ Zip: ________________
Phone Number: ________________________Date of Birth: _______________
Occupation: ____
Referred by: ____
Emergency Contact Name:____
Relationship: __________________ Phone Number: _____________________
Primary Care Physician: ____
Email: ____

☐ Please check if you do not wish to be contacted via phone or be left a voice mail

Health History

Do you or did you previously have a history of any of the following? If yes, please describe your condition in the space provided. List any medications in the margins for the following:

		YES	NO	Explain
1.	Heart Problems/Chest Pains:			
2.	High or Low Blood Pressure:			
3.	Respiratory Problems:			
4.	Labored Breathing:			
5.	Diabetes:			
6.	High Cholesterol:			
7.	Cancer:			
8.	Epilepsy or Seizures:			
9.	Anxiety/Depression:			
10.	Dizziness:			
11.	Sleeping Problems:			
12.	Easy Fatigue:			
13.	Arthritis:			
14.	Headaches:			
15.	Leg Cramps:			
16.	Swelling of Hands or Feet:			
17.	Abdominal/Bowel Disorders:			
18.	Indigestion:			

Patient Name: ________________________

19.	Irregular Menstruation:			
20.	Do you Smoke?			
21.	Have you ever had any history of substance abuse?			
22.	Major illness or hospitalization in the last 3 years including surgery?			
23.	Any other health problems not listed?			
24.	Are you pregnant or breast feeding?			
25.	Do you have any drug allergies?			
26.	Are you allergic to bees?			
27.	Have you ever had or been diagnosed with Glaucoma?			

List all your medications:

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FAMILY & MEDICAL HISTORY *(circle one)*

Female Organ Problems Y/N Cancer Y/N High Blood Pressure Y/N

Kidney Trouble Y/N Diabetes Y/N Low Blood Pressure Y/N

If Yes, Please explain:

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If you answered yes to any of the above questions, a physician approval may be needed before participating in this weight loss program.

28. How would you rate your overall health? *(Circle one)*
    Excellent Good Fair Poor

29. Have you ever been on a supervised weight loss program before? Y / N If Yes, explain

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What is your weight loss goal? ____

____

What have you done in the past to achieve these goals?

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____

Patient Name: ________________________

30. How much time can you devote to exercising each week? ____________________

31. How frequently do you eat? (How many meals per day?) ____________________

32. Do you eat out? Y/N If so, how many times per week? ____________________

33. What is your fluid intake PER DAY? List number of glasses/cups in each category.

WATER ______COFFEE ______ SODA _______ TEA ______ ENERGY DRINKS ______ ALCOHOL ______ OTHER ________

34. Do you take supplements? If so, what kind and how much?

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35. Please finish this statement. (Use the back of the page if necessary.)
The best way to describe my nutritional habits is …____

____

General Information:
Do you have any of the following? *Check any that apply*

Sweet Cravings	☐	Alcohol Cravings	☐
Bread Cravings	☐	Salt Cravings	☐
Cheese Cravings	☐	Night Hunger	☐

Do you have specific weaknesses when trying to lose weight? ___________________________________

On a scale from 1-10 how motivated are you to losing weight? ___________________

How did you hear about Valley Medical Weight Control?

- Internet ☐
- Craigslist ☐
- The Clipper/Savvy Shopper ☐
- Money Mailer ☐
- Friend/Family ☐
- TV Y Mas ☐

Other___________________

PATIENT CONSENT:

Patient Consent: The above information is a true representation of my current health status. I have read and understand the above and do hereby agree to treatment administered to me, including medications for weight control. I, the undersigned, having been informed by Valley Medical Weight Control, PC of the hazards and possible consequences involved in treatment by medications, supplements, injections for the purpose of weight loss, nevertheless consent to such treatment and agree to hold Valley Medical Weight Control, P.C. free and harmless for any claims, demands, or suits for damages from any injury or complications whatever, save negligence, that may result from such treatment.

Notice: All patients may receive medications dispensed by VALLEY MEDICAL WEIGHT CONTROL *(or receive written prescription to take to a pharmacy of their choice for a fee).*
If you suspect you are pregnant, discontinue medication. Pregnant or nursing mothers should not be taking this medication.

Signed: ______________________________________ Date:__________________

IF PATIENT IS UNDER THE AGE OF 18, A PARENT OR LEGAL GUARDIAN MUST SIGN ABOVE

Patient Name: ________________________

For Clinic Use Only

Weight	
Height	
BMI	
BP	
PR	
Heart/Rhythm	
Thyroid	
Eyes	

DX:

_______ year old F / M patient PTC in NAD for weight loss. Weighs________ lbs with a BMI of ________.
Patient's goal weight _________. Relevant medical hx of ____
Diet hx of appetite suppressants Y / N ____
Exercise Y / N __________________________with dietary habits_________________________________
Breakfast Y / N Patient will start ____
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P:

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