VALLEY MEDICAL PATIENT FORM

First Name_____ Last Name_____
Address _____City_____State_____ Zip _____
Date of Birth _____ Age _____ Sex M / F
Phone _( )_____
Emergency Contact _____ Phone _( )_____
Primary Care Physician _____
Email : _____@_____
□ *Check if you do not wish to be contacted via phone or email*

Have you ever had or currently have any of the following

	Yes	No	Not Sure		Yes	No	Not Sure
Heart Trouble	☐	☐	☐	Heart Palpitations	☐	☐	☐
High Blood Pressure	☐	☐	☐	Indigestion	☐	☐	☐
Low Blood Pressure	☐	☐	☐	Bowel Issues/Constipation	☐	☐	☐
Diabetes	☐	☐	☐	Glaucoma	☐	☐	☐
High Cholesterol	☐	☐	☐	Leg Cramps	☐	☐	☐
Anxiety/Depression	☐	☐	☐	Dizziness	☐	☐	☐
Fatigue	☐	☐	☐	Epilepsy/Seizures	☐	☐	☐
Allergies	☐	☐	☐	Frequent Headaches	☐	☐	☐
Allergic to Lidocaine	☐	☐	☐	Irregular Menstruation	☐	☐	☐
Cancer	☐	☐	☐	Fibroids/Ovarian Cysts	☐	☐	☐
Thyroid Trouble	☐	☐	☐	Female Organ Problems	☐	☐	☐
Shortness of Breath	☐	☐	☐	Kidney Trouble	☐	☐	☐
Difficulty Sleeping	☐	☐	☐	Do you Smoke	☐	☐	☐
Have Phenylketonuria (PKU).	☐	☐	☐	Pregnant or Breast Feeding	☐	☐	☐
Gall bladder Issues	☐	☐	☐	History of Substance Abuse	☐	☐	☐

What is your GOAL WEIGHT? _____lbs

Your statement of present health is ☐ Excellent ☐ Good ☐ Fair/Poor

Have you ever been on a weight loss program before? ☐ Yes ☐ No
If yes, please explain _____

Do you exercise? ☐ Yes □ No

How often? ☐ Daily ☐ 4-5x a week ☐ 2-3x a week ☐ 1x a week ☐ Rarely ☐ Never

Patient Name_____

Do you drink:	Y	N	
Coffee	☐	☐	
Soda	☐	☐	
Energy Drinks	☐	☐	
Alcohol	☐	☐	
Do you eat 3 meals a day?	☐	☐	
Do you often eat out?	☐	☐	If so, how many times per week? _____
Do you crave sweets?	☐	☐	
Do you crave carbs?	☐	☐	
Do you crave salt?	☐	☐	

Do you take any medications? ☐ ☐

List all your medications _____

_____

Do you take any supplements? ☐ ☐

List all your supplements _____

_____

How did you hear about us? ☐ The Clipper ☐ Savvy Shopper ☐ Valpak ☐ Hispanic Publication

☐ FaceBook ☐ Internet ☐ Friend/Family* _____

** We offer FREE WEIGHT loss for friends and family referrals. Ask a member of our staff about of referral program.*

PATIENT CONSENT

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

Notice: *all patients may receive medications dispensed by Valley Medical (or receive written prescription to take to a pharmacy of their choice for a fee.) Please be aware all patients must be approved by our physician for all medications and show consistent weight loss to continue on medications.*

IF YOU SUSPECT YOU ARE PREGNANT DISCONTINUE ALL MEDICATIONS, SUPPLEMENTS or INJECTIONS. PREGNANT OR NURSING MOTHERS SHOULD NOT BE TAKING THIS MEDICATION.

Signed: _____ Date: _____

If patient is under the age of 18, a parent or guardian must sign above.