Last Name		**First Name**		**DOB**	
Street		**City**	**St**	**Zip**	
Phone ( )	**Cell ( )**		**Work ( )**		
Email:					
Best method to contact?	**Cell #** / **Home #** / **Work #** / **Email**				
Nurse to fill out:					Nurse Initial:
Wt:	Ht:	Goal Wt:	Age:	B/P:	HCG:

PAST MEDICAL HISTORY:

Yes	No		Yes	No		Yes	No	
		High Blood Pressure			Insomnia			Lupus / Rheum Arthritis
		Cancer			Kidney Failure			Glaucoma
		Depression/Anxiety			Seizures			PCOS/Insulin Resistance
		Diabetes			Drug Addiction			Thyroid Problems
		Heart Problems			Liver Disease			Clotting Disorder

SURGERIES:

Yes	No					
		Weight Loss Surgery?	When?	Other major Surgeries?	What and When?	
		Gallbladder Removal?	When?			

MEDICATIONS: ☐ ***I DO NOT take ANY prescription medications.***

☐ I take herbal / vitamin supplements: _____

☐ I take the following prescription medications:

	Name of Rx	Dose(mg)	**WHAT CONDITION** is it taken for?
1			
2			
3			
4			
5			
6			

☐ ***DRUG ALLERGIES:*** ☐ ***I HAVE NO KNOWN DRUG ALLERGIES***

	Med allergic to:	Type of Reaction:	***SEVERITY OF REACTION***			Occurred at What Age?
1			Mild	Moderate	Severe	
2			Mild	Moderate	Severe	
3			Mild	Moderate	Severe	

☐ ***WEIGHT LOSS PROGRAMS YOU HAVE TRIED IN THE PAST:***

Medically Supervised Treatment: (describe) _____

Have you ever taken Prescription Weight Loss Meds? _____

☐ ***FAMILY MEDICAL HISTORY:***

☐ Diabetes ☐ Obesity ☐ Heart Rhythm Problems
☐ High Blood Pressure ☐ Heart Attack ☐ Thyroid Problems
☐ Cancer _____ ☐ Mental Breakdown ☐ Other _____

☐ ***PREGNANCY HISTORY:*** ☐ N/A

☐ I am pregnant / I have reason to believe I could be pregnant / I plan to get pregnant during treatment.
☐ # Births _____ Dates: _____
☐ Tubal Ligation _____ Hysterectomy_____ Partial / Complete
☐ Birth Control _____

CAFFEINE USE: ☐ NONE
☐ Coffee Cups/day _____
☐ Tea Cups/day _____ Green/Herbal/Black
☐ Cola (any)

ALCOHOL USE: ☐ NONE
☐ Wine Total # Drinks:
☐ Beer _____ per week
☐ Liquor _____ per month

TOBACCO USE: ☐ NONE ☐ Socially
_____ Packs per Day _____ # years smoking

ACTIVITY LEVEL:
☐ **Inactive** - no regular physical activity/sit down job
☐ **Light Activity**- no organized physical activity during leisure time.
☐ **Moderate Activity** - occasionally involved in weekend activities ie golf/tennis/jogging/swimming.
☐ **Vigorous Activity** - Extensive physical exercise for at least 60 min per session 4+ x /week.

Dietary / Nutrition Restrictions:

I, the undersigned, understand that I will be taking medication for the sole purpose of losing weight. I have been advised of the effects and side effects this medication may produce, and further advised that if adverse effects are realized- to STOP the medication and call the clinic ASAP. In understand that if I become pregnant or attempt to become pregnant I will stop any and all medications given me. I hereby affirm that the above medical information is correct and accurate. I give my permission to any provider at MD Weight Loss and Wellness to review my medical records. I also acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____

Date: _____