*Name*______________________________ *Date*____________________

*Address*______________________________ *Date of Birth*____/____/_____

*City*________________________ *State*__________ *Zip*_______________

*Telephone*____________________ *Social Security Number*_______________

MEDICAL HISTORY

Place an "✓" next to any of the following conditions that you have now or have ever had:

____High blood pressure	____Liver disease	____Anemia
____Heart disease	____Gallbladder disease	____Asthma
____Chest pain	____Diabetes	____Allergies
____Shortness of breath	____Thyroid disease	____Psychiatric illness
____Irregular heart beat	____Severe headaches	____Depression
____Swelling of feet	____Seizures or convulsions	____Alcoholism
____Dizziness	____Kidney disease	____Other illness

Explain: ____

Medications you are currently taking: ______________________________

____

How have you tried to lose weight before (list all weight loss plans or medications you have tried to lose weight)? ______________________________

(OFFICE USE ONLY)

Physical Exam: WT________ HT_______ BP______/______P_______ BMI ________

HEENT______________________ SKIN______________________

COR______________________ ABDOMEN______________________

LUNGS______________________ EXTREM______________________

NECK______________________ NEURO______________________

EKG______________ BLOOD PROFILE______________ CONSENT SIGNED______________

DX: ____

PLAN:____

____

____

____

____M.D.

NAME: ______ DATE: ______

ADDRESS: ______ ZIP: ______

HOME PHONE: ______ AGE: ______ BIRTH DATE: ______

SOCIAL SECURITY #: ______ OCCUPATION: ______

EMPLOYER: ______ BUSINESS PHONE: ______

ADDRESS: ______

PERSONAL PHYSICIAN: ______

ADDRESS: ______

REFERRED BY: ______ REASON FOR VISIT: ______

IN CASE OF EMERGENCY - NOTIFY: ______ PHONE: ______