Patient Information Form

Patient Name:_____

LAST FIRST MI

Name you prefer to be called:_____

Patient Address: _____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Date of Birth:_____Age:_____Sex:_____Height:_____Email:_____

Primary Care Physician: _____

List any medications (prescribed/over the counter)_____

_____

Who can we thank for referring you to our office?_____

Financial Policy:

Thank you for choosing Complete Medical Weight Loss Clinic. We are honored to service you during your weight loss journey. Please be advised that payment for your visit is due in full at the time services are rendered. For your convenience, we accept Visa, Mastercard, American Express, cash and personal checks. No refunds are given at any time. A $10.00 fee will be charged for all returned checks. We do not submit claims to insurance companies. If you would like to do so on your own, we will be happy to provide you with an itemized receipt. We are unable to accept returns on any medicine after it has been dispensed to you, due to medicine dispencing regulations.

I have read and understand the above statements and have agreed to these statements.

_____ _____

PATIENT SIGNATURE DATE

WOMEN (please answer the following)

Are you pregnant or planning to become pregnant? Y N

Are you breastfeeding? Y N

Are you currently taking birth control? Y N

Do you have regular periods? Y N

Are you going through menopause? Y N

WEIGHT HISTORY

I have tried to lose weight _____ times in the last 5 years.

I have tried: (please check) Jenny Craig ____Weight Watchers____ Nutrisystems_____First Place_____
Healthy Weigh_____Other_____

I lost _____ pounds. I didn't lose any _____ I gained back what I lost _____

These medications have helped me lost weight in the past:

___Phentermine (Fastin, Ionimin, Adipex) ___Diethylprpion (Tenuate) ___Redux

___Phendimetrazine (Melfiat, Bontril) ___Pondimin ___Didrex ___"Phen-Fen"

The medications I took:

___Gave me no ill side effects ___Made me ill and I had to stop

Please answer each question as honestly as you can. If you do have a problem with compulsivity, it will be easier for you to lose weight if you are also treated for this condition. The doctor will discuss this with you during your consultation.

Do you binge every week? Y N

Are you concerned with your body image? Y N

Do you induce vomiting when you overeat? Y N

Do you use laxitives or diuretics? Y N

Do you have an obsession with food? Y N

If you answered yes to 3 or more of these questions, it is possible that you may have a compulsive eating problem or are well on the way to having one.

Additional Comments & Thoughts_____

_____

I understand that it is my responsibility to notify the physician of any problems I may have with my program or medications. I will notify my physician if my family doctor prescribes any medications or treats any illness which has not been previously reported to this clinic. I acknowledge that I have read and understand the above and will assume full responsibilty for relating my medications to this clinic and my family doctor.

_____ _____

PATIENT SIGNATURE DATE

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____Date of Birth:_____Date:_____

Please list any and all allergies to foods or medications_____
_____

Do you drink alcohol Y N Number of drinks per week_____
Do you smoke? Y N Quit when?_____ Number of years smoked_____
List all current medications:

_____
_____

List all hospitalizations:

_____

List all surgeries:

_____

Chronic illnesses:

_____

Alcholism or drug problem: Y N If Yes, describe:_____

Family History:	Mother	Father	Other		Mother	Father	Other
Cancer	____	____	____	Diabetes	____	____	____
Heart Disease	____	____	____	Stroke	____	____	____
Obesity	____	____	____	Autoimmune disorders	____	____	____
High Blood Pressure	____	____	____	Endocrine disease	____	____	____

Please circle either Y (yes) or N (no) for each question. Answer all of the questions in each section. If you are unsure, circle the truer one.

Respiratory System			**Neurological**		
Shortness of breath (at rest)	Y	N	Headaches	Y	N
Night Sweats	Y	N	Dizziness	Y	N
Productive Cough	Y	N	Numbness	Y	N
Bloody Cough	Y	N	Epilepsy	Y	N
Tuberculosis	Y	N	Seizure disorder	Y	N
Pneumonia	Y	N	Fainting	Y	N
Cardiovascular			**Genitourinary**		
Chest Pain	Y	N	Enlarged Prostate	Y	N
Hypertension	Y	N	Frequent nighttime urination	Y	N
Heart Attack	Y	N	Blood in Urine	Y	N
Heart Failure	Y	N	Burning upon urination	Y	N
Heart Murmur	Y	N			
Mitral Valve Prolapse	Y	N	**Ears, Eyes, Nose & Throat**		
Palpitations(racing heart beat)	Y	N	Seasonal Allergies	Y	N
Peripheral vascular disease	Y	N	Hearing Loss	Y	N
Edema (swelling of hands/feet)	Y	N	Glaucoma	Y	N
			Cataracts	Y	N

MEDICAL HISTORY QUESTIONNAIRE (continued)

Patient Name:_____Date of Birth:_____Date:_____

Gastrointestinal			**Endocrine**		
Abdominal Pain	Y	N	High thyroid (hyper)	Y	N
Heartburn	Y	N	Low thyroid (hypo)	Y	N
Ulcer	Y	N	Diabetes	Y	N
Acid Reflux	Y	N	Low blood sugar	Y	N
Vomiting/Nausea	Y	N	Gout	Y	N
Excessive Pain	Y	N			
Rectal Bleeding	Y	N			
Colitis	Y	N	**Bones, Joints, Muscles**		
Gallstones	Y	N	Aching muscles/joints	Y	N
Constipation	Y	N	Low Back Pain	Y	N
Diarrhea	Y	N	Muscle Cramps	Y	N
Psychological			**Other**		
Depression	Y	N	Cancer	Y	N
Bipolar depressive Illness	Y	N	Anemia	Y	N
Schizophrenia	Y	N	Fatigue	Y	N
Anxiety/Panic Disorder	Y	N	Hot/Cold Spells	Y	N