New Results Medical Weight Loss

The Healthy Weight Loss Program That Delivers Results!

Please Print

PERSONAL INFORMATION

Name: _____

Date of birth: _____ Age: _____ Gender (please circle one): Male Female

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Is it alright to call you at the numbers listed? Y N **Circle best number to reach you on.**

E-Mail for appointment reminders: _____

Primary Care Physician: _____

_____

Date of Last Physical: _____

Where do you work/Occupation? _____

_____

Spouse / Significant Other or Next of Kin:

Name: _____ Phone: _____

Relationship: _____

In Case of Emergency: _____

Contact: _____ Phone: _____

Whom may we thank for referring you today / How did you hear about us? _____

How old were you when you started gaining excessive weight? _____

1. Are you aware of any medical reasons for the weight gain? **Y** **N** If yes please explain: _____

_____

2. Is your weight now stable? **Y** **N** Are you continuing to gain weight? **Y** **N**

3. What prior attempts have you made to lose the weight? _____

_____

What were the results? _____

4. What do you think will be the benefits of your weight loss? _____

_____

5. Current weight: _____ Goal Weight: _____ Height: _____

6. Are you taking any kind of **medications, herbal therapies, non-prescription drugs,** etc**?** **Y** **N**

If yes list: _____

7. **Do you have allergies to any medications?** **Y** **N** If so, what: _____

Have you ever had an adverse reaction to any medicine? **Y** **N** If so, describe: _____

_____

8. Any history of the following: Heart Disease, Cardiovascular disease (heart or blood vessel), Stroke? **Y** **N** If so, describe:

_____

_____

Signature: _____ **Date:** _____

Name: _____

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Any history of the following continued:

Pulmonary disease (lung) or asthma? **Y** **N** _____

Diabetes? **Y** **N** _____

Hypoglycemia? **Y** **N** _____

Thyroid, Adrenal or PCOS problems? **Y** **N** _____

Migraines or Seizures? **Y** **N** _____

GI, Liver, Gallbladder problems? **Y** **N** _____

Kidney or Bladder problems? **Y** **N** _____

Hypertension / High Blood Pressure? **Y** **N** _____

Orthopedic problems or surgeries? **Y** **N** _____

Have you ever had problems with extreme nervousness, anxiety or panic attacks? **Y** **N** _____

_____

Have you ever had any weight loss surgery (liposuction, gastric banding / stapling, intestinal bypass, etc)? **Y** **N**

_____

Other Surgeries? **Y** **N** _____

9 . Have you ever taken, or are currently taking any of the following medications? (Circle)

Adipex	Belviq	Didrex	Lamictal	Phentermine	Xenical
Avelox	Bontril	Diet Pills	Meridia	Qsymia	Ephedra
Avert	Cafcitt	Effexor	Mirapex	Tenuate	Phenmetrazin
Belamine	Dexidrene	Lonamin	Noroxim	Vosplre	Zyprexa

10. Do you take Ritalin, Adderall, or any other stimulant therapies? **Y** **N** _____

11. Do you take any of these MAOI's? Isocarboxazid (Marplan) / Phenelzine (Nardil) / Selegiline (Emsam) / Tranylcypromine (Parnate) **Y** **N** _____

12. Daily Caffeine Intake? **Y** **N** Amount: _____

Signature: _____ **Date:** _____

INTERNAL USE BELOW THIS POINT

BMI: _____ or Body Fat: _____% Other _____

BP: _____ Pulse: _____

Age: _____ Height: _____ Starting Weight: _____ Goal: _____ BMI: _____

Impression: EKG _____

Diagnosis: Overweight / Obese / Morbidly Obese / Localized Adiposity / Cosmetic Weight Loss

Labs: CBC, CMP, Lipid, TSH, T4

Side Effects Explained: **Y** **N**

Plan: B12 / MIC **Y** **N** Also approved for B6 / B12 / MIC **Y** **N**

Start PHEN D or AMINO

Physicians Notes: _____

_____

Physicians Exam (if abnormal, describe): _____

_____

_____

_____

_____ Medical Staff _____ MD