Medical WeightLoss & Wellness, Inc.

Getting to Know You

Today's Date: ________________________ Date of Birth: ___________________________ Age: _______________

Name: ____ Gender: M / F

Last First MI

Street Address: ____

City: ____ State: _____________________ Zip: ___________________

Mobile: ( ) ________________________________ Alternate: ( ) ________________________________

Occupation/Place of Employment: ____

E-mail (will not be distributed outside of MWLW): ____

Parent or Guardian Signature (if patient is a minor): ____

Relation

Primary Doctor: ____ Phone: ( )__________________

Cardiologist (if applicable): ____ Phone: ( )__________________

Endocrinologist (if applicable): _____________________________________ Phone: ( )__________________

How did you hear about us?: ______________________________________ (Employee initial/date): _______________

Does the above individual attend the Racine or Oak Creek clinic or unsure?(please circle)

We will never share your name per laws of HIPAA. Only one name allowed for referral credit.

Weight History

Height: _________ ft. __________ in. What is you approx. target weight?: ______________________

Maximum Weight: _______________ When: ____

What weight were you last "content" with?: ______________ When: ____

In the past I have: Lost (how much): ___________ Did not lose: _________ Gained back what I lost: ___________

Previous weight loss program(s) *(circle)*:

Jenny Craig Nutrisystem Weight Watchers HCG Other/None: ____

These medications have helped me lose weight in the past *(circle)*:

Phentermine Phendimetrazine "Phen-Phen" Belviq Contrave Other: ____________________________________

I exercise *(circle)*: at a gym on my own not at all

Type of exercise and how often?: ____

____

____

Medical/Surgical History

Food or Drug Allergies? ____
____
____

Habits: Smoke? Y N How much/often?: ______________
Alcohol? Y N How much/often?: ______________

Family History	Father	Mother	Other
Cancer	______	______	______
Diabetes	______	______	______
Heart Disease	______	______	______
Hypertension	______	______	______
Psychiatric Disorder	______	______	______
Stroke	______	______	______
Obesity	______	______	______

List all current medications/supplements: **NONE**
____
____
____
____

List all surgeries and hospitalizations: **NONE**
____
____
____
____

Chronic illnesses: **NONE**
____
____
____

Circle Y (Yes) or N (No) for each question. Answer all questions.

Respiratory System

Shortness of Breath (at rest)	Y	N
History of Pneumonia	Y	N
Asthma	Y	N
Sleep Apnea	Y	N
COPD	Y	N

Cardiovascular

Hypertension (high blood pressure)	Y	N
Heart Attack &/or Heart Stents	Y	N
Heart Failure (CHF)	Y	N
Pacemaker/Defibrillator	Y	N
Open Heart Surgery	Y	N
Heart Murmur	Y	N
Mitral Valve Prolapse	Y	N
Palpitations/Heart Arrhythmia	Y	N
Peripheral Vascular Disease	Y	N
Edema (chronic swelling of hands/feet)	Y	N
High Cholesterol	Y	N

Gastrointestinal

Abdominal pain	Y	N
Heartburn/GERD	Y	N
Ulcer	Y	N
Colitis or Crohn's	Y	N
Gallstones	Y	N

Psychological

Depression	Y	N
Bipolar Depressive Illness	Y	N
Schizophrenia	Y	N
Anxiety/Panic Disorder	Y	N
Alcoholism/Drug Problem	Y	N

Neurological

Headaches	Y	N
Seizure disorder	Y	N
Brain Aneurysm/Stroke	Y	N

Ears, Eyes, Nose & Throat

Seasonal Allergies	Y	N
Hearing Loss/Hearing Aids	Y	N
Glaucoma	Y	N
Cataracts	Y	N

Endocrine

High Thyroid (hyper)	Y	N
Low Thyroid (hypo)	Y	N
Diabetes	Y	N

Bones, Joints, Muscle

Chronic back pain	Y	N
Aching muscles/joints	Y	N
Osteoporosis	Y	N
Arthritis	Y	N
Gout	Y	N

Other

Cancer Type: ______________________	Y	N
Anemia	Y	N
Kidney Stones	Y	N

Women Only

Are you pregnant now?	Y	N
Are you breastfeeding?	Y	N
Are you taking birth control?	Y	N

Type (circle): Birth Control Pill
IUD
Nuva Ring
Depo Shot
Other: ______________

Last Period: ____________________

Menopause	Y	N
Hysterectomy	Y	N

I understand it is my responsibility to notify Medical Weightloss & Wellness, Inc. of any problems/concerns I may have with the program or medications/supplements. I will notify MWLW if I am prescribed any medications or diagnosed with an ailment not reported above. I grant MWLW permission to access my online pharmacy history for prescription medication verification purposes. I acknowledge that I have read and understand the above and will assume full responsibility for communicating any medication changes, additional medications prescribed or new diagnosis's to this clinic.

Patient Signature: ____ Date: ____________________