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 "Fen-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? _____

_____

Vegan or Vegetarian (circle):_____

_____

Habits: Smoke? Y N How much/often?: _____

Alcohol? Y N How much/often?: _____

Family History	**Father**	**Mother**	**Other**
Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Hypertension	_____	_____	_____
Heart Attack	_____	_____	_____
Obesity	_____	_____	_____
Psychiatric Disorder	_____	_____	_____
Stroke	_____	_____	_____

List all current medications/supplements *(name & dose)*:

_____

_____

_____

_____

List all surgeries: **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.

Signature: _____ Print Name: _____ Date: _____