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 (*never* 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 our **Racine** or **Greenfield** clinic or **unsure**? *(please circle)*

Per HIPAA, we will never disclose your name. Only one name please.

Weight History

Height: _____ ft. _____ in. What is your 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 MWLW 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. Please 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
Colitis or Crohn's	Y	N
Gallstones	Y	N

Psychological

Depression and/or Anxiety	Y	N
Bipolar Disorder	Y	N
ADD/ADHD	Y	N
Schizophrenia	Y	N
Alcohol/Drug Dependency	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	Y	N
Type: _____		
Anemia	Y	N
Kidney Stones	Y	N

Women Only

PCOS	Y	N
Are you pregnant now?	Y	N
Are you breastfeeding?	Y	N
Are you taking birth control (*circle*)?	Y	N

Birth Control Pill
IUD
Nuva Ring
Depo Shot
Other: _____

Last menstrual period: _____

Menopause	Y	N
Hysterectomy	Y	N

I understand it is my responsibility to notify Medical WeightLoss & Wellness, Inc. of any issues/concerns I have with the program or medication/supplements. I will notify MWLW of changes to my prescription medication regimen or of new medical diagnoses. I grant MWLW permission to access my online pharmacy history for prescription verification purposes. By supplying my contact information, I grant MWLW permission to contact me via email or text message for appointment reminders as well as occasional clinic promotions/news. *At MWLW, we respect your privacy and will never share your personal information. At any time, you may unsubscribe by using the link at the bottom of each email.* By signing below, I acknowledge I have read, understand, and consent to the above.

Signature: _____ Print Name: _____ Date: _____