MEDICAL WEIGHT LOSS SOLUTIONS - NEW PATIENT DEMOGRAPHICS

Date: _____/_____/_____

Name: _____ M F ☐ ☐

Social Security Number (Last 4 digits): _____ Birth Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

How did you hear about our services? _____

Email: _____

*IN SUBMITTING MY E-MAIL, I AUTHORIZE MEDICAL WEIGHT LOSS SOLUTIONS TO UTILIZE THE E-MAIL ADDRESS LISTED ABOVE FOR CORRESPONDENCE OF MONTHLY NEWSLETTERS, APPOINTMENT REMINDERS, AND FUTURE MARKETING MATERIAL.

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact and Personal Information Authorization

I authorize the following individual(s) to have access to my records, if necessary.

Name: _____ Phone: _____

Relationship: _____

Important Numbers

Pharmacy: _____ Location: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Patient Signature: _____ Date: _____/_____/_____

Name: _____ DOB: _____/_____/_____ Height: _____ Weight: _____lbs.

Social History

Have you ever smoked? Yes☐ No☐

Do you currently smoke? Yes☐ No☐ Quantity/Day: _____

Do you consume alcohol? Yes☐ No☐ Quantity: _____

Questionnaire

Have you previously attempted a weight loss program? Yes☐ No☐

Have you lost weight only to gain it back? Yes☐ No☐

Do you have a history of diabetes or blood sugar issues? Yes☐ No☐ (Note current medication on the following page.)

Do you have a history of heart or blood pressure issues? Yes☐ No☐ (Note current medication on the following page.)

Do you have a history of depression? Yes☐ No☐ (Note current medication on the following page)

Do you have a history of thyroid issues? Yes☐ No☐ (Note current medication on the following page)

Have you ever taken weight loss medications? Yes☐ No☐ (Note current medication on the following page)

Have you ever taken an SSRI? Yes☐ No☐

Do you have a history of hormone issues such as PMS, PCOS, menopause, hot flashes, decreased libido, breast discomfort?

Yes☐ No☐

Please describe _____

Do you have fatigue, moodiness, or decreased mental clarity? Yes☐ No☐

Weight loss Medication You have tried. _____

What is your actual weight loss goal (ex. pounds and inches)? ____ lbs. _____ inches

What is your timeline for that goal and is there a specific reason for the timeline? _____ days/months

Please list specific areas that you are trying to target. _____

Describe your current exercise routine? _____

Describe your current daily diet/food (calorie) intake? _____

Please tell us your WHY or primary reason for losing weight? (ex. health, specific event such as a wedding or trip, look good, or get back to yourself, etc.) _____

Name: _____ DOB: _____/_____/_____ Height: _____ Weight: _____lbs.

Surgical History

Procedure	Year of Surgery	Notes or Complications

Current Medications

Medication Name	Dosage and MG

Allergies: _____

Family History

	Self	Mother	Father	Brother	Sister
Arthritis					
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Thyroid					
Neuropathy					

ACKNOWLEGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES, INFORMED CONSENT FOR EXAMINATION AND TREATMENT, APPOINTMENT CANCELLATION POLICY, AND PHOTO RELEASE DISCLOSURE

Date: _____/_____/_____

Patient Name (please print): _____ Birth Date: _____/_____/_____

I acknowledge that I was provided and read the Medical Weight Loss Solutions Notice of Privacy Practices.

Patient Signature: _____

I acknowledge that I was provided and read the Medical Weight Loss Solutions Informed Consent for Examination and Treatment.

Patient Signature: _____

I acknowledge that I was provided and read the Medical Weight Loss Solutions Appointment Cancellation Policy.

Patient Signature: _____

I acknowledge that I was provided and read the Medical Weight Loss Solutions Photo Release Disclosure. Currently, I….

Accept ☐ **Decline** ☐

Patient Signature: _____

For Medical Weight Loss Solutions use only.

Complete this section if this is not signed and dated by the patient or patient representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Medical Weight Loss Solutions' Notice of Privacy Practices, Informed Consent for Examination and Treatment, Appointment Cancellation Policy, and Photo Release Disclosure, but was unable to for the following reason:

☐ Patient refused to sign ☐ Patient unable to sign ☐ Other

Employee Signature: _____ Date: _____/_____/_____