Patient Information Form

Last Name_________________________ First Name ______________________________ MI_______

Address______________________________City_________________State______ Zip_____________

Home Phone (   )________________ Cell (   )_______________ Work (   )___________________

Date of Birth_____-_____-________ Social Security # _______-_______-________

E-mail Address: ____________________________________

Name of emergency contact: _________________ Relation: ________________

Phone number for emergency contact: (   )________________

Your current doctor: _________________________ Tel: (   )____________________

How did you first hear about our office? ____________________

Who referred you to our practice? __________________________

Please Initial Below:

_________ There is a $25 fee for missed appointments. Please notify us at least 24 hours in advance to avoid this fee. Thank you.

__________ I understand that there are no refunds once payment has been made.

__________ I understand that being off the program and absent from this office for 16 or more weeks requires a package reinstatement fee of $180. This fee will include an additional 4 weeks of medication.

_____________________________   ______________

Signature   Date

Flip over – Please complete backside

For what medical / psychological conditions are you currently being treated: ____________________

____

Present Medications: ____

Allergies to medications: ______________________________Diet Restrictions: __________________

Other physicians currently treating you: ____

List any previous surgeries or hospitalizations (include # of miscarriages and live births): ___________
____

Females: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No
When was your last menstrual cycle? __________ Are your cycles regular? ☐ Yes ☐ No
How many pregnancies have you had? __________ How many live births? _________________

Do you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars
Do you drink alcohol? ☐ Yes ☐ No Circle: Wine/beer/cocktails How many times per week?____
Do you drink caffeinated beverages? ☐ Yes ☐ No Which?_____ How many per day? ________

Weight History:
Heaviest (outside of pregnancy) _______lbs (year) Lowest (within past 5 yrs) ______lbs (year)
Have you ever taken appetite suppressants before ☐ Yes ☐ No

If yes, which appetite suppressant: ____________________. Dose: ___________. What year _______.

Did you experience any significant side effects from taking the medication? ☐ Yes ☐ No ____________.

Have you ever had any of the following (please check all that apply):

☐ Chest pain or pressure ☐ Palpitations ☐ Shortness of breath ☐ Ulcers

☐ Hypertension ☐ Dizzy spells ☐ Depression

☐ Heart attack ☐ Cancer ☐ Constipation ☐ Heartburn

☐ Stroke ☐ Diabetes ☐ Skin Disorders

☐ Headaches ☐ Arthritis ☐ Kidney Stone ☐ Glaucoma

☐ Urinary Infection ☐ Blood in Stool Other: _________________

Do you have any trouble falling or staying asleep? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

How many hours of sleep do you get per night? _________ Do you feel rested in the AM: ☐ Yes ☐ No

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Family Medical History (Please list medical conditions and major health events ie stroke, heart attack, cancer)

Father: _______________________________ Mother: ______________________________

Brother: ______________________________ Sister: _______________________________