AMERICAN
WEIGHT LOSS CENTERS
MEDICAL WEIGHT MANAGEMENT

Date: _____/_____/_____

Last Name_____ First Name _____ MI_____
Address_____City_____State_____ Zip_____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

Date of Birth_____-_____-_____ Gender: □M □F

E-mail Address: _____Name of Significant Other _____

Additional Information

Person to notify in case of emergency

Name: _____ Telephone ( ) _____

Your current Doctor: _____ Telephone ( )_____

How did you first hear about our office? _____

Who referred you to our practice? _____

Please initial below to acknowledge both statements:

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

_____ I understand there is a $50 fee for missed appointments. I can avoid this fee by notifying the staff at least 24 hours in advance.

_____ 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.

Expiration Dates:

_____ I understand that any remaining time on a 26 week and 12 week package will expire after 12 months and 6 months of absence respectively. I cannot reclaim any remaining time after these periods of absence.

I understand that payment is due in full at time of treatment.

_____

Patient Signature

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

_____

Present Medications: _____

Allergies to medications: _____

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 How many glasses/beers per day?_____

Do you drink caffeinated beverages? ☐Yes ☐No How many per day? _____

Weight History:
Heaviest (outside of pregnancy) _____lbs (year) Lowest (within past 5 years) _____lbs (year)

Have you ever taken appetite suppressants ☐Yes ☐No
If yes, which appetite suppressant: _____. Dose: _____. What year _____.

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

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

☐ Hypertension ☐ Dizzy spells ☐ TB / lung disorder ☐ Depression

☐ Heart attack ☐ Cancer ☐ Hemorrhoids ☐ Hepatitis

☐ Stroke ☐ Diabetes ☐ Skin Disorders ☐ Digestive Problems

☐ Headaches ☐ Arthritis ☐ Memory Loss ☐ Glaucoma

☐ Allergies or eczema ☐ Hard of Hearing ☐ Cataracts ☐ Kidney Stone

☐ Urinary Infection ☐ Blood in Stool Other: _____

Family Medical History (Specify relationship)

Father: _____ Mother: _____

Brother(s): _____ Sister(s): _____