

VALLEY MEDICAL WEIGHT LOSS

First Name _____ Last Name _____
 Address _____ Zip _____
 Date of Birth _____ Age _____ Sex M / F
 Phone _() _____
 Emergency Contact _____ Phone _() _____
 Primary Care Physician _____
 Email : _____@_____

Check if you do not wish to be contacted via phone or email

Have you ever had or currently have any of the following

	Yes	No	Not Sure		Yes	No	Not Sure
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Issues/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to Bees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids/Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Female Organ Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have Phenylketonuria (PKU).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is your GOAL WEIGHT? _____ lbs

Your statement of present health is Excellent Good Fair/Poor

Have you ever been on a weight loss program before? Yes No

If yes, please explain _____

Do you exercise? Yes No

How often? Daily 4-5x a week 2-3x a week 1x a week Rarely Never

Patient Name _____

Do you drink: Y N
Coffee
Soda
Energy Drinks
Alcohol
Do you eat 3 meals a day?
Do you often eat out? If so, how many times per week? _____
Do you crave sweets?
Do you crave carbs?

Do you take any medications?
List all your medications _____

Do you take any supplements?
List all your supplements _____

How did you hear about us? The Clipper Savvy Shopper Valpack TV Y Mas
 Internet Friend/Family* _____

** We offer FREE WEIGHT loss for friends and family referrals. Ask a member of our staff about of referral program.*

PATIENT CONSENT

The above information is a true representation of my current health status. I have read and understand the above and hereby agree to treatment administered to me, including medications for weight loss. I, the undersigned, having been informed by Valley Medical Weight Loss, P.C. of the hazards and possible consequences involved in treatment by medications, supplements, injections, and nevertheless consent to such treatment and agree to hold Valley Medical Weight Loss, P.C. free and harmless of any claims, demands, or suits for damage from any injury or complications whatsoever, save negligence, that may result in such treatment.

Notice: *all patients may receive medications dispensed by Valley Medical Weight Loss (or receive written prescription to take to a pharmacy of their choice for a fee.*

IF YOU SUSPECT YOU ARE PREGNANT DISCONTINUE ALL MEDICATIONS, SUPPLEMENTS or INJECTIONS. PREGNANT OR NURSING MOTHERS SHOULD NOT BE MAKING THIS MEDICATION.

Signed: _____ Date: _____

If patient is under the age of 18, a parent or guardian must sign above.