OPTIONS
MEDICAL WEIGHT LOSS

Name _____ DOB _____ Age _____ Date _____

Height _____ Weight _____ Gender F M

How did you hear about us? _____ If referred by someone, who? _____

Please answer the following questions honestly so we can do our best to help you reach your goals.

What made you decide to do something about your weight today? _____

_____

Who encouraged you to lose weight? _____ Can you commit to one visit a week? Y N

What important reason, special occasion, or goal date do you have for wanting to lose weight? _____

_____

How important to you is it that you lose weight? _____

How many pounds would you like to lose? _____ How fast do you want to be slim, trim, & fit? _____

Have you ever attended any other weight reduction centers, if so, which ones? _____

What kinds of diets have you tried on your own? _____

What is the longest you've been able to stick with a diet? _____

Does your family support your weight loss efforts? Y N

Have you been advised by your family physician to lose weight? Y N

Do you eat because of emotions? Y N *If yes, please explain*: _____

_____

On average, which of the following reflects your daily eating habits? (Please check all that apply)

_____ 3 meals with healthy snacks
_____ 3 meals
_____ 2 meals or less
_____ Graze; small frequent meals
_____ Skip breakfast or other meals
_____ Generally eat on the run
_____ No regular eating pattern
_____ Often crave sweets/carbs

Please check your current level of exercise:

_____ None
_____ Light exercise *1-3 times per week, easy pace, stretching, walking, etc.*
_____ Moderate exercise *2-3 times per week, moderate pace, some weights, etc.*
_____ Heavy exercise *3-4 times per week, vigorous pace, weights, fast running, etc.*

Consult Notes

_____
_____
_____
_____
_____
_____

New Patient Intake

Name: _____ Date: _____

Mailing Address: _____

City _____ State _____ Zip _____

Email address: _____

Phone # (H)_____ (W)_____ (Other)_____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact:_____ Relation:_____

Phone #: (H) _____ (W) _____ (C) _____

What is your chief complaint today? _____

Please list any additional health complaints _____

Please list any surgeries (with dates) and/or medical conditions (past & present) _____

_____

Family History: Please specify members of your family including extended family who have these illnesses.
Cancer: _____ Hypothyroidism:_____
Heart Disease: _____ High Blood Pressure: _____
Hypoglycemia: _____ Obesity: _____

Current Medications/Supplements		
Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies _____

Some of our programs use medications that are not deemed safe to take while pregnant or breastfeeding.
Are You Pregnant, or breast feeding? Yes ❑ No ❑

What was the date of your last menstruation? Date: _____

Signature: _____ Date: _____

Review of Systems

Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Please mark if you have experienced any of these symptoms within the ***last month****:*

Neurological
___ Migraines
___ Headaches
___ Slurring of speech
___ Ringing in ear
___ Dizziness
___ Pins/Needles Arms
___ Pins/Needles Legs
___ Cold Feet
___ Fainting
___ Fever

Ear/Nose/Throat
___ Altered taste/smell
___ Night Blindness
___ Sore Throat
___ Gingivitis
___ Nose bleeds
___ Blurred Vision
___ Light bothers eyes

Cardiovascular
___ Chest pain
___ Palpitations- racing heart beat
___ Swelling in hands/feet
___ Anemia

Respiratory
___ Recurrent respiratory infections
___ Asthma
___ Chest congestion
___ Wheezing
___ Frequent sneezing
___ Shortness of breath

Gastrointestinal
___ Stomach pains or cramping
___ Constipation
___ Reflux or heartburn
___ Bloating
___ Gas
___ Nausea or vomiting
___ Bowel/ bladder changes

Musculoskeletal
___ Joint pain
___ Arthritis
___ Chronic pain
___ Muscle aches
___ Neck pain
___ Back pain
___ Arm pain
___ Knee/leg pain
___ Night pain
___ Jaw problems

Skin
___ Eczema
___ Dermatitis
___ Excessive sweating
___ Rashes
___ Brittle nails
___ Hair loss
___ Increased bleeding
___ Easy bruising
___ Numbness/tingling
___ Cold sweats

Genitourinary
___ Uterine fibroids
___ Ovarian cysts
___ Cancer (breast, ovarian, prostate,uterine)
___ Prostate problems

Emotional/Mental
___ Depression
___ Anxiety
___ Mood swings
___ Irritability
___ Memory loss
___ Confusion
___ Nervousness

Energy
___ Fatigue
___ Hyperactivity
___ Restlessness
___ Insomnia
___ Decreased libido
___ Stress
___ Tension

Weight
___ Decreased appetite
___ Weight gain
___ Inability to lose weight
___ Food cravings
___ Binge eating
___ Water retention
___ Sudden weight loss

Allergies
___ Hives
___ Runny nose
___ Itchy/Watery eyes
___ Congestion

___ **None of the above**

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with myself or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient Signature_____**Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Advanced Health Weight Loss S.C. (DBA) Options Medical Weight Loss. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the medical treatments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature_____**Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____