OptionsMedicalWeightloss.com
info@optionsmedicalweightloss.com
1147 S. Wabash Avenue
Chicago, IL 60657
Phone: (312) 360-1604
Fax (312) 971-4414:

**MEDICAL HISTORY FORM**

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

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**Please answer all of the following questions**

1: Which body area/areas or condition would you like treated? _____

_____

| | YES | NO |
|---|---|---|
| 2: Have you tried to lose fat in that area prior to today? If so what have you tried ? | ☐ | ☐ |

Please List:_____

_____

3: Have you looked into any medical/non-medical solutions for your problem area?
If so which solutions have you inquired about or completed? ☐ ☐

Please List:_____

_____

4: 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.*

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**Please answer all of the following questions continued** **YES NO**

5. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

*Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.*

Please List: _____

_____

6. Do you have **ANY** current or chronic skin conditions? ☐ ☐

*Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.*

Please List: _____

7. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

_____

8. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐

Please List: _____

_____

9. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? ☐ ☐

Please List: _____

10. Do you currently have ANY wounds, rashes, or open lesions? If so what areas? ☐ ☐

Please List:_____

11. Do you have history of an active abdominal hernia or abdominal hernia repair? ☐ ☐

Please List:_____

12. Are you currently pregnant and/or breastfeeding? ☐ ☐

13. Have you had prior treatment with parenteral gold therapy (gold sodium thiomalate)? ☐ ☐

14. Are you currently taking antiplatelets, thrombolytics, anti-inflammatories (ex: Advil, Aleve, or Aspirin), or anticoagulants? If so which ones? ☐ ☐

Please List: _____

15. Do you have an active tan or have you been exposed to sun and/or tanning bed in last 7 days? Is so, what type of exposure and when were you last exposed? ☐ ☐

Please List: _____

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# 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**_____