CALIFORNIA MEDICAL WEIGHT LOSS

GENERAL INFORMATION

NAME: _____ DATE:_____

D.O.B: _____ AGE: _____ GENDER: _____ DRIVER'S LICENSE #: _____

CURRENT ADDRESS: _____ CITY , STATE & ZIP: _____

HOME#: _____ CELL #: _____

OCCUPATION: _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT NAME: _____ EMERGENCY CONTACT #: _____

EMAIL ADDRESS:_____ WOULD YOU LIKE TO RECEIVE PROMOTIONS? □ YES □ NO

MEDICAL HISTORY: check all that apply

- □ HEART DISEASE/HEART ATTACK/CHEST PAIN
- □ HIGH BLOOD PRESSURE
- □ RESPIRATORY PROBLEMS _____
- □ DIABETES _____
- □ HIGH CHOLESTEROL
- □ CANCER _____
- □ ARTHRITIS
- □ GLAUCOMA
- □ EPILEPSY/ SEIZURES
- □ ANXIETY/OCD
- □ DEPRESSION/ BIPOLAR/ ADHD
- □ DIZZINESS/VERTIGO/HEADACHES
- □ SLEEPING PROBLEMS
- □ THYROID DISEASE _____
- □ RECENT DRUG/ALCOHOL ABUSE
- □ HEARTBURN
- □ KIDNEY STONES/ GALLBLADDER DISEASE
- □ OTHER _____
- □ CROHN'S DISEASE
- □ DIARRHEA
- □ CONSTIPATION
- □ IRRITABLE BOWEL SYNDROME
- □ ANEMIA _____
- □ FIBROIDS
- □ CELIAC DISEASE

LIST IF ANY OR WRITE "NONE":

CURRENT MEDICATIONS: _____

KNOWN ALLERGIES: _____

SURGERIES & DATE: _____

FAMILY HISTORY: check all that apply

- □ KIDNEY PROBLEMS
- □ HEART PROBLEMS
- □ HIGH BLOOD PRESSURE
- □ CANCER
- □ DIABETES
- □ OBESITY

SOCIAL HISTORY: check 'YES' or 'NO' to answer	YES	NO
DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY? _____	□	□
DO YOU DRINK ALCOHOL? IF SO, HOW OFTEN? _____	□	□
DO YOU DRINK CAFFEINE? IF SO, HOW OFTEN? _____	□	□
ARE YOU PREGNANT OR BREAST FEEDING?	□	□
DO YOU PLAN ON PREGNANCY WITHIN THE NEXT 3 MONTHS?	□	□

HAVE YOU EVER BEEN ON A SUPERVISED WEIGHT LOSS PROGRAM? _____ NAME & YEAR: _____

HAVE YOU EVER TAKEN APPETITE SUPPRESSANTS BEFORE? YES □ IF SO, NAME _____ □ NO

HOW MUCH DO YOU EXERCISE PER WEEK? _____ HOW MANY MINUTES PER DAY? _____

HOW MANY MEALS DO YOU EAT PER DAY? _____ SNACKS? _____

ANY DIETARY RESTRICTIONS? _____

WHAT IS YOUR WEIGHT LOSS GOAL? _____

HOW DID YOU HEAR ABOUT **CALIFORNIA MEDICAL WEIGHT LOSS**? check all that apply

- □ DROVE-BY
- □ YELP
- □ GROUPON
- □ GOOGLE
- □ INTERNET
- □ FLYER
- □ OTHER:_____
- □ REFERRED BY: _____

PATIENT CONSENT

The above information is a true representation of my current health status. I have read and understand the above and do hereby agree to treatment administered to me. I, the undersigned, have been informed by California Medical Weightloss, Inc., of the possible hazard and consequences involved in treatment. Nevertheless, I consent to such treatment and agree to hold California Medical Weightloss, Inc. free and harmless for any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

PATIENT 'S SIGNATURE & DATE _____