Patient Basic Information Form
(to be filled out by patient)

Your Name: Last _____ First_____ M.I.____

Name you prefer to be called: _____

Your Address: Street _____ Apt/Suite # _____

City: _____ State: _____ Zip Code: _____

Home Phone (Including Area Code): _____ Cell: _____

Birth date: _____ Current Age: _____ Sex: M F

Your e-mail address: _____ Referred by: _____

How did you hear about us? (please check all that apply)

___Radio ___Mail-out ___Internet ___Saw a Sign ___Television
___Newspaper ___Word of Mouth ___Movie ___Facebook ____Other _____

ALLERGY INFORMATION

Are you allergic to Sulfa type medications, or any other medications? Yes No

EMERGENCY CONTACTS
(AT LEAST 2 OTHER PEOPLE)

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Physician: _____ Phone _____

FINANCIAL POLICY

Thank you for selecting Achieve Medical Weight Loss for your health care. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept Visa, MasterCard, Discover, Checks and Cash. I have read and understand all of the above and have agreed to these statements.

Patient's (or Guardian's) Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

Full Name: _____DOB_____ Sex: M F

Present Health Status:

1. Are you in good health at the present time, to the best of your knowledge? Yes No

Explain a "no" answer:

_____

2. Are you under a doctor's care at the present time? Yes No

If "yes," for what?

_____

3. Are you taking any medications at the present time Yes No

Prescription Drug(s) and Dosage:

Drug(s):_____ Dosage: _____

Over the Counter medication, vitamins, supplements, etc.

Product(s): _____ Dosage: _____

4. Any allergies to any medications? Yes No

Please List: _____

5. History of High Blood Pressure? Yes No At what age: _____

6. History of Diabetes? Yes No At what age: _____

7. History of Heart Attack or Chest Pain or other Heart condition? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No Migraines? Yes No

Medications for Headaches: _____

10. History of Constipation? (difficulty in bowel movements) Yes No

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes N

13. Any Surgery? Yes No Specify with date: (List all, use back of page if needed)

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

___ Gallbladder Disorder	___ Jaundice	___Kidneys	____Nervous Breakdown
___ Pleurisy	___Scarlet Fever	___Ulcers	____Rheumatic Fever
___ Tuberculosis	___Drug Abuse	___Anemia	____Blood Transfusion
___ Pneumonia	___Arthritis	___Gout	____Whooping Cough
___ Eating Disorder	___Typhoid Fever	___Chicken Pox	____Bleeding Disorder
___ Osteoporosis	___Liver Disease	___Lung Disease	____Heart Valve Disorder
___ Thyroid Disease	___Heart Disease	___Alcohol Abuse	____Psychiatric Illness
___ Cancer	___Measles	___Other	

FAMILY HISTORY

Tell us of your family's medical history to the best of your ability including these items as they apply: Age | General Health | Diseases | Overweight | Cause of Death

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Has any blood relative ever had any of the following?

High Blood Pressure: Yes No Who: _____

Kidney Disease: Yes No Who: _____

Heart Disease/Stroke: Yes No Who: _____

At what age did they have their heart / stroke problems? _____

Gynecological History (females only)

Do you have a normal menstrual cycle Y N Date last period started? _____

Is there any possibility you could be pregnant at this time Y N

Have you ever been pregnant? Y N If yes, how many times have you been pregnant? _____

How many pregnancies did you carry to term? _____ Were any of your births premature? _____

Any birth defects? Y N

Are you currently on any method of birth control? Y N

If yes, what type _____

NUTRITIONAL EVALUATION

1. What is the main reason for your decision to lose weight? _____

2. Desired weight: _____ in how many months would you like to be at this weight? _____

3. Weight at 20 years old? _____ Weight one year ago? _____

4. When did you begin gaining excess weight? (give reasons, if known)

_____

5. What is the most you have weighed (non-pregnant) and when? _____

6. Is your spouse, fiancée or partner overweight? Yes No If yes, appx much? _____

7. How often per week do you eat out? _____

8. How often per week do you eat "fast food?" _____

9. Foods you are allergic to: _____

10. Foods you strongly dislike: _____

11. Foods you crave: _____

12. Times of day or month that you crave food? _____

13. Do you drink coffee or tea? Yes No How much daily? _____

14. Do you wake up hungry in during the night? Yes No How often? _____

15. Previous diets you have followed: Name and/or description of diet and your results:

_____

LIFESTYLE CONSIDERATIONS

This information will assist us in assessing your particular problem areas as it relates to weight, health, and establishing your medical management. Thank you for your time and patience in completing this form.

1. Do you drink alcohol? Yes/No Daily? Yes/No Weekly? Yes/No Occasionally? Yes/No

2. Smoking Habits (choose only one)

_____ You have never smoked cigarettes, cigars or a pipe

_____ You have quit smoking ____ years ago and have not smoked since

_____ You smoke _____ cigarettes per day

3. Activity Level: ____Inactive: no regular physical ____Light activity: no organized physical activity ____Moderate activity: occasionally involved in activities _____Heavy activity: consistent or regular participation in active sports at least three times per week. _____Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session four times per week.