MEDICAL HISTORY

CONFIDENTIAL

The following information is necessary for our counselors to determine your eligibility for the program and establish your needs during the weight loss period. Please answer all questions accurately to the best of your knowledge. Thank you.

I. PERSONAL INFORMATION **DATE:_____**

Name:_____Email: _____Home Phone:_____

Address:_____Business Phone:_____

City:_____State:_____ZIP:_____ Age:_____Birthdate_____

Employed By:_____Occupation:_____

Spouses Name:_____ Employed By:_____Occupation:_____

II. MEDICAL HISTORY

1. Personal Physician:_____Date Last Examination_____

2. Medications: You Are Currently Taking (Including Birth Control Pills, Aspirin, Laxatives, Etc.). Notate Dosage, Strength And Frequency:
_____

3. Have You Ever Taken: Cortisone: Yes____ No____ Fertility Drugs: Yes____ No____ Appetite Suppressants: Yes____ No____

4. Vitamins You Are Currently Taking:_____

5. Known Medicine Allergies:_____

6. Other Allergies:_____

7. Are You Currently Under A Physician's Care For Any Medical Condition Requiring Treatment: Yes____ No____ If Yes, Please Describe:_____

8. If You Have Had Surgery Recently, Explain:_____

9. What Other Surgeries Have You Had (List Year)?_____

10. List Reasons (And Year) For Any Other Hospitalizations Or Major Illnesses_____

11. Are You Now Pregnant Or Breast Feeding? Yes____ No____ Explain:_____
_____

12. Are You Currently On Any Specific Diet From Your Physician Or A Dietician? Yes____ No____ Explain:_____
_____

13. Do You Smoke? Yes____ No____ If So, What/How Much?_____

14. Do You Drink: Beer____ Liquor____ Wine____ How Much Per Week?_____

III. Please Check If You Have Had Or Been Treated For Any Of The Following. (If Yes, Please Explain):

GASTROINTESTINAL	KIDNEY	CARDIOVASCULAR	PSYCHOLOGIC
____indigestion	____kidney stones	____heart trouble of any sort	____depression
____ulcer disease	____kidney failure	____irregular pulse	____anxiety
____colitis	____nephritis	____hypertension	____anorexia nervosa
____diverticulitis	____kidney/bladder infection	____poor circulation	____binge/gorge syndrome
____constipation	GYN	____stroke	____alcoholism
____diarrhea	____premenstrual syndrome	____other	____drug dependence
____other	____other	GENERAL	____other emotional or psychiatric trouble
RESPIRATORY	BLOOD	____cancer	NEUROLOGIC
____asthma	____anemia	____fluid retention	____convulsions
____sinusitis	____other blood trouble	____arthritis	____stroke
____emphysema	HORMONAL	____fatigue	____fainting spells
____other	____diabetes	____recurrent infections	____other
LIVER DISEASE	____hypoglycemia	____AIDS	
____hepatitis	____thyroid disease	____other	
____cirrhosis	____gout		
____jaundice	____growth problem		
____other			

IV. WEIGHT LOSS HISTORY

1. **Current Weight_____**
2. **What You Would Like To Weigh?_____**
3. **How Long Have You Been Overweight?_____**
4. **Has Your Physician Recommended That You Lose Weight? Yes____ No____**
5. **Is Anyone Else In Your Family Overweight (Spouse, Parents. Etc.)?_____**
6. **How Long Have You Been Thinking About Losing Weight?_____**
7. **What Do You Do For Recreation?_____**
8. **Do You Feel That You Have Good Eating Habits?_____**
9. **Are You Having Any Physical Discomfort Associated With Your Weight?_____**
   _____
10. **Previous Methods Of Weight Reduction And Results:_____**
    _____
11. **Is, Or Will Your Spouse Be Aware That You Are On Our Program? Yes____ No____**
12. **Why Do You Want To Lose Weight? Check All That Apply:**

____Special Event	**____Career**	**____Appearance**
____Birthday	**____Social Life**	**____Personal Life**
____Anniversary	**____Recreation**	**____Self**
____Health	**____Clothing**	**____Other_____**

Are You Ready To Make The Commitment To Lose Weight? Yes____ No____

You Learned Of Our Program Through:	**PLEASE CHECK ONE:**	**BE SPECIFIC**
	☐ **Physician Referral**	**Name:_____**
	☐ **Client Referral**	**Name:_____**
	☐ **TV Station**	**Name:_____**
	☐ **Radio Station**	**Name: _____**
	☐ **Newspaper**	**Name:_____**
	☐ **Other**	**Explain:_____**

I Understand that The Above Information Will Be Kept Confidential And Is Accurate To The Best of My Knowledge:

Client Signature_____ Date_____

Counselor_____ Date_____

Release of Medical Records
I hereby give authorization for The Ageless Weight Loss and Wellness Center to release all pertinent information regarding my past medical history, lab results, and any other confidential chart information to:

_____
Physician Name or Medical Facility

_____
Physician or Medical Facility Address

_____ _____
Client Signature Date Witness Signature Date

May we contact you by email with informative materials helpful to your weight loss and weight management success, and special sales benefits of interest to you, our valued client? Your address will be held in strict confidence and never forwarded or sold to any other organization, required under the Privacy Act. ☐ YES ☐ NO

_____
Please Print Your E-mail Address Clearly