Mobile Weightloss Center

New Patient History (Pellet)

Name: _____, _____
First Last

Date: ___/____/___

DOB: ___/____/____ , Age: _____

Please complete the following form. This information will assist us in your evaluation today.

Name of Primary Care Physician: _____

Name of OBGYN: _____

MEDICAL HISTORY:

1. List current medications including prescription medications, vitamins, herbals or diet supplements and any over-the-counter medications. List dosages and the dates started. Attach medication list if you have one. _____

_____

_____

_____

2. List any allergies and the reactions to the allergy:

_____

_____

3. Past medical problems and dates of problems: (hypertension, diabetes)_____

_____

4. Past surgeries and dates of each surgery: _____

_____

5. Please circle below if you are experiencing any of the following symptoms:

Fatigue Weight Gain Decreased Libido Hot Flashes Night Sweats Acne Hair Growth

SOCIAL HISTORY:

1. Do you currently smoke? No Yes
2. Did you previously smoke? No Yes
3. Do you drink alcohol? No Yes
4. Did you previously drink? No Yes
5. Do you currently use recreational drugs? No Yes
6. Have you ever used recreational drugs? No Yes
7. Do you exercise? No Yes- How often per week_____