# Medical Aesthetics and Wellness Center
# Weight Loss Patient Intake

Full Name:_____
DOB:_____

Home Address:

_____
_____

City: _____ State:_____
Zip:_____

Mobile Phone: _____ Email:
_____

How Did You Hear About Us?

_____

If Referred, By Whom?

_____
(Please print patients name for referral program)

Primary Care Physician:

_____

Highest (non-pregnant) weight as adult:

_____

Lowest weight as an adult:

_____

Long term
goal:_____
_____

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What are your challenges with food?

_____

Do you crave carbs? _____ Do you crave sugar?

_____

Do you drink your calories? Y N Alcohol Soda Coffee/Starbucks?

How many average servings of alcohol do you consume per week?

_____

Do you consume diet drinks? Y N How many a day?

_____

How much caffeine do you consume daily?

_____

Do you smoke Tobacco? Y N

Are you active? Y N

Do you exercise? (other than walking)

_____

Do you have any injuries or physical limitations that keep you from being active?

_____

_____

Have you taken a prescribed appetite suppressant before? Y N

If yes, did you have side effects?

_____

Have you successfully dieted before? _____ What diets have you tried?

_____

_____

_____

**<u>Do you have any of the following medical conditions? (Circle all that apply)</u>**

Hypertension Diabetes Elevated Cholesterol Cancer Thyroid

Stroke Irregular heart Heart Disease Ulcers Seizures

Depression Anxiety Bipolar disorder Anorexia/bulimia Insomnia

Any other medical conditions?
_____

Medications **AND** Doses:
_____

_____
_____

Supplements:
_____
_____

Allergies:
_____
_____

If you are female and have a uterus, how are you preventing pregnancy? _____

Are you breastfeeding? Y N

*I certify that the preceding medical, medication and personal history/statements are true and correct. I am aware that it is my responsibility to inform the doctor/staff of my current medical or health conditions and to update this history should any changes occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.*

Signature: _____ Date:
_____

# Weight Loss Patient Expectations

1. Appetite suppressants are controlled substances. Because of that reason, If a patient has not lost a total of 10 pounds in three consecutive months (the equivalent of just over three pounds a month), the appetite suppressants will be not be prescribed until 5 pounds from your last weight-in is lost. You may

continue with our program but without the medication to achieve the 5-pound minimum.

2. Female patients who are trying to get pregnant or believed to be pregnant may not take the appetite suppressants due to its side effects.

3. We value everyone's time therefore patients are expected to arrive on time. If you are 5 minutes late, we do have the right to reschedule your appointment.

4. If you have (3) three "no call, no shows," you will be dismissed from our practice. We require 24 hours in advance for cancellations.

5. For those who choose to do the HCG diet, please understand that the reduction in calories is what helps you lose the weight. HCG is useful to minimize the loss of muscle mass that is often associated with rapid weight loss.

6. Should you have any forms that require Doctor's signature, it may take up to 7 business days to have it completed.

Name_____

Date_____