Advanced Weight Loss Clinic

~Changing Lives One Pound At A Time~

117 N. Main St # B
Sand Springs, OK 74063
Office: 918-241-LOSE (5673)

CONFIDENTIAL PATIENT INFORMATION
PLEASE FILL IN ALL PORTIONS OF THIS FORM. IF YOU NEED HELP PLEASE ASK

DATE:_____

Name of Patient: _____ E-Mail:_____

Permanent Address:_____
City State Zip

Phone (home) _____(cell)_____(work) _____

Date of Birth:_____ Sex:_____

Height: _____ Weight: _____ Ideal weight:_____

Weight loss goal for this year:_____ Date you want to hit goal:_____

Do we need to be discreet when contacting you?_____

Best time to call:_____

How did you hear about us?_____Who can we thank?_____

_____ _____ _____

Patient's Signature: Parent or Guardian Signature Date:

Patient Questionnaire & Exam

Name: _____ Date of birth: _____
Occupation/employer: _____
Reason for visit: Weight Loss/Appetite Suppressant

If you have been in a hospital overnight this year due to illness/operation (do not include normal pregnancies please start with the most recent event:

Year	illness / operation	Year	illness / operation

Please check if you (self) or any blood relatives had any of the following conditions.

	YES	NO		Yes	No
RECENT WEIGHT LOSS			LIVER DISEASE/HEPATITIS		
MIGRAIN HEADACHES			KIDNEY/ BLADER PROB		
EPILEPSY/ CONVULSIONS			NEUROLOGICAL PROB:		
EYE DISEASE			MEMORY PROBLEMS		
HEARING DISORDER			CONFUSION		
RECURRENT NOSE BLEEDS			ARTHRITIS		
ANGINA CHEST PAINS			OSTEOPOROSIS:		
HEART ATTACK HIGH BLOOD PRESSURE			CANCER-TYPE		
ASPIRIN			BLEEDING DISORDER		
BOWEL PROBLEMS			BLOOD TRANSFUSION(S)		
Diabetes			Gallbladder disease		

LIST ALL MEDICATIONS YOU TAKE:
MEDICATION DOSE TIMES PER DAY

_____
_____
_____
_____
_____
_____

DO YOU SMOKE: Y/ N PKG/DAY_____YEARS:_____
ALCOHOL: Y/ N DRINKS / WK _____
COFFEE / TEA: Y/ N CUPS/DAY_____

Allergies to medicine: _____

What does HRT rate run:_____Todays HRT rate reading: _____ Insomnia Y N
What does BP run: / Todays BP reading: _____/_____ Anxiety Y N

Date of last ment period: _____
Regular Cycle: Y N
Pre-menstrual dysphonic disorder: Y N
Are you currently using birth control: Y N Type:_____
Number of pregnancies:_____
Number of births: _____
Number of abortions:_____
Number of miscarriages: _____

Do you consider yourself selfish?_____
Do you consider yourself a snack eater?_____

Do you have any other problems for which you have been seeing a doctor on a regular basis?_____

_____

Office use only: Appetite suppressant:_____ Wellness Consultant Ins:_____
DDV:_____ PIF:_____ COP:_____