



Patient Information & History Form

General Information: (Print)

Form ***MUST*** be completed in its entirety, if not applicable...simply mark N/A.

Full Name _____ Date of Birth _____
Street Address _____ City/State/Zip _____
Home Phone(____) _____ Work/Cell Phone(____) _____
Occupation _____ Employer _____
Social Security # ____ - ____ - ____ Family Physician _____
Sex: M/F Current Age: ____ Height: __' __" Weight: ____ lbs

Medical History:

Current Medications: _____

Date of last seen by Family Physician: _____

Surgeries or Major Procedure, with dates: _____

Do you have any known Allergies (i.e. – Food/Medicinal): _____

If yes, please list: _____

Do you Smoke: _____ If yes, how much per day: _____

Do you Drink Alcohol: _____ If yes, how much/day: _____

Have you ever been treated for Drug/Alcohol Abuse: _____

If yes, when & what for/results: _____

Have you ever taken Diet Pills before? _____ If yes, what kind, when & prescribed by whom: _____

Medical History cont.:

Are you currently under any other Medical Practices and/or Physicians Treatment for Medical Weight Loss? _____ If yes, Name of Physician & last time seen: _____

Have you ever tried Dieting & Exercise to help you lose Weight before? _____ If yes, when & how: _____

Do you suffer any Physical conditions that would inhibit you from exercise? _____ If yes, please describe: _____

What is your "Goal Weight" & when do you expect to attain that weight: I would like to weigh _____ lbs in _____ Months.

Female Only: Date of Last Menses: _____

I, _____, do hereby consent to the Treatment prescribed by the Attending Physician of New Image Weight Loss Centers, LLC...up to & including the use of Prescription Medications for Medical Weight Loss. Further, I commit to the use of the Prescribed Medications for the Sole purpose of Medical Weight Loss assistance.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

-----**OFFICE USE ONLY**-----

Initial Exam:

Weight: _____ lbs Height: _____ ' _____ " BMI: _____

Blood Pressure: _____ / _____ Pulse: _____ Thyroid: _____

Cardiac: _____ Lungs: _____ Leg Edema: _____

Other: _____

Medications Prescribed: _____

Nurse/Medical Asst Signature: _____

Physician Signature: _____

PATIENT PHOTO ID VERIFIED: _____ by _____