

Sea Mist Medical Weight loss, INC.

Patient Health History

Name <u>:</u>									
Addres	ss:		City						
State:_	Zip code	Phone: (ce	II)	(home)	(home)				
Date o	f Birth:	Occupatio	n						
Emerg	ency Contact Name <u>:</u>								
Relatio	onship	т	eleph	one #					
Primar	y Care Physician <u>:</u>								
E-mail	address				<u>-</u>				
Driver	License #			Exp. Date					
How m	nuch weight would you	like to lose?_							
For the	e followings please circl	e Yes or No							
Do yοι	ı want us to leave mess	age for you v	via em	nail or phone? Yes No					
Have y	ou ever been in any me	edical superv	ised V	Veight loss program before?	Yes	No			
Do yοι	ı have any history of the	e following?	Pleas	e circle (Yes or No)					
A)	Drug or Food Allergies	Yes	No	(if yes, what is it?)					
B)	Latex allergies	Yes	No						
C)	Leg cramps	Yes	No						
D)	Headaches	Yes	No						
E)	Arthritis	Yes	No						
F)	Sleeping problems	Yes	No						
G)	Dizziness/Vertigo	Yes	No						
H)	Anxiety/Depression	Yes	No						
I)	Epilepsy/Seizures	Yes	No						

J)	High Cholesterol	Yes	No										
K)	Cancer	Yes	No										
L)	Heart Problems	Yes	No										
M)	Kidney or liver disease	Yes	No										
N)	Diabetes	Yes	No										
O)	Asthma	Yes	No										
P)	High blood pressure	Yes	No										
Q)	Low blood pressure	Yes	No										
R)	Are you pregnant or breastfo	eeding		Yes	No								
S)	When was your last menstru	When was your last menstrual cycle?											
T)	How many time/week do you exercise?												
U)	Major illness/ hospitalization	n withii	n last 6	mont	hs Yes	No							
V)	V) Have you ever had a substance abuse problem within the last 6 month? Yes No												
W)	Do you have Glaucoma?		Yes	No									
X)	Do you have a thyroid condi	tion?	Yes	No									
Y)	Do you drink alcohol?		Yes	No									
Z)	Do you smoke?		Yes	No	(if yes, how n	nany pack pe	er day)						
AA) Family history of hea	rt disea	se	Yes	No								
	Please list all current medica												
	What are your food craving?												
	How did you hear about us? Community Guide Postcard Drive b	oc	Mont	hly	Friend's Na		per Magaz -	ine					
	The above information is a t	rue rep	resent	ation (of my current h	ealth status.							
	If you suspect that you are p Weight loss, Inc. Pregnant or	•	•		-	-	-						
	Signature:					Date <u>:</u>							

If PATIENT IS A MINOR (under 18 year old) parent or legal guardian must sign on his or her behalf.