CLIENT MEDICAL SUMMARY

The following information is necessary for our staff to determine your eligibility for the program and to establish your needs during the weight loss period. Please answer all questions accurately and to the best of your knowledge.

Date:_____

PERSONAL INFORMATION

Name_____
H. Phone_____ W. Phone_____
Cell Phone:_____ Email_____
Address_____
City_____ State_____ Zip_____
Age_____ Occupation_____ Employed by_____

How did you hear about us? _____

HEALTH HISTORY

Personal Physician_____ Date of last Physical Exam_____
Medication now taking_____
Known allergies_____

Are you currently under a physician's care for any acute or chronic medical treatment requiring regular treatment? YES NO. If yes please describe._____

Have you ever received treatment for any of the following?

YES	NO		YES	NO	
___	___	cancer	___	___	arthritis
___	___	liver disease	___	___	ulcers
___	___	pancreatic disease	___	___	osteoporosis
___	___	bladder infection	___	___	colitis
___	___	gout	___	___	hypoglycemia
___	___	high blood pressure	___	___	diabetes
___	___	heart attack	___	___	chest pain
___	___	diverticulitis	___	___	stroke
___	___	enteritis	___	___	hepatitis
___	___	kidney disease			

	YES	NO
Do you have colostomy?	___	___
Have you had intestinal bypass surgery?	___	___
Are you currently pregnant or breast feeding?	___	___

Do you have any of the following?

YES	NO		YES	NO	
___	___	diabetes	___	___	chest pains
___	___	heart trouble	___	___	much sweating
___	___	gall bladder trouble	___	___	frequent colds
___	___	kidney trouble	___	___	bladder trouble
___	___	stomach ulcers	___	___	painful urination
___	___	cancer	___	___	asthma
___	___	tuberculosis	___	___	poor digestion
___	___	loss of hair	___	___	bloating
___	___	bleeding gums	___	___	stomach burning
___	___	sore mouth	___	___	poor bowel action
___	___	sinus trouble	___	___	loose bowel action
___	___	itchy skin	___	___	rectal pain
___	___	skin rash	___	___	fast pulse
___	___	allergies	___	___	palpitation
___	___	arthritis	___	___	irregular heart
___	___	leg cramps	___	___	lung trouble
___	___	swollen hands	___	___	difficulty sleeping
___	___	dry skin	___	___	severe nervousness
___	___	brittle fingernails	___	___	oily skin
___	___	dizziness	___	___	headache
___	___	tiredness	___	___	fainting spells
___	___	back ache			

Are you *currently* taking any of the following?

YES	NO	
___	___	drugs
___	___	hormones
___	___	stomach medicine
___	___	laxatives
___	___	heart medicine

Have you *ever* taken any of the following?

YES	NO	
___	___	thyroid
___	___	insulin
___	___	cortisone
___	___	birth control

1. Why did you come to Physician's Weight Loss Centers? _____

2. Does your extra weight make you feel uncomfortable? **YES NO SOMETIMES**

3. Has your clothing size increased in the past two years? **YES NO**
   If yes, from size_____ to size_____

4. Present age_____ What was your weight when you felt you were at your best_____
   Your age then____

5. Present Weight_____ Dress/Slack Size_____

6. Desired Weight_____ Desired Dress/Slack Size_____

7. What, if anything, have you done previously to lose weight?
   ____ Exercise ____ Pills ____ Fasting ____ Diet: _____

8. How successful were you?
   ____ Very Good ____ Good ____ Average ____ Poor

9. Have you gained weight since then? **YES NO**
   If yes, why? _____

10. Which describes you best?
    I eat too much:
    ____ when nervous ____ for pleasure ____when upset
    ____ Other _____

11. Do you take time to plan/cook your meals? **YES NO**
    Or do you prefer fast food? **YES NO**

12. How do you reward yourself for dieting? _____

13. What does your doctor think of your weight? _____

14. Do those close to you wish you would take part in a weight loss program? **YES NO**
    If yes, who?

15. Will your family/friends help you diet? **YES NO**
    If not, who will you turn to for support? _____

16. Do you know how much weight you can expect to lose on our program? **YES NO**

17. Does your schedule allow you a few minutes 2-3x a week to visit our weight loss counselors? **YES NO**

18. Why is it important for you to lose weight?
    ____ Appearance
    ____ Doctor's suggestion
    ____ Tight clothes
    ____ Upcoming event
    ____ General Health
    ____ Self-esteem
    ____ Other: _____

List what you normally have for:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____

Snacks	Beverages	Desserts
_____	_____	_____
_____	_____	_____

Comments:_____
_____
_____
_____
_____