WEIGHT LOSS PROGRAM

Patient History:

Name: ____

Address: ____

City: ______________________________ State: __________ Zip: ______________

Date of Birth: ______________________________ Age: __________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________________ Drivers License#: ______________________

How did you hear about us: ____

Height __________ Weight __________ Sex: Male ______Female______ Date of Last Period: __________

Past Medical History: ____

Current Medications/Dosage: ____

Allergies: ____

Family History: ____

Weight History:

At what age did you first become overweight? ______________ Year ______________

Describe the circumstances surround your weight gain at its start: ______________________

What do you think is the cause of your weight gain? ______________________________

Your present weight: ______________ Your goal weight: ______________

What was your highest weight? (Excluding pregnancies) ______________ How long ago? ______________

What was your lowest weight? ______________ How long ago? ______________

Have you ever stayed the same weight for 10 or more years? Yes No

Have you attempted to lose weight before? Yes No Most pounds lost? ______________

How long did it take you to lose the weight? ______________________________

Describe your previous methods of weight loss: ______________________________

When do you do most of your overeating? ______________________ Where? ______________

Do you currently have any medical concerns? (List) ______________________________

______________________________ ______________

Signature of Patient **Date**