"Weigh To Go" Weight Loss Centers

Please Print **Date** _____

Name _____ **Marital Status** **M ( ) S ( ) D ( ) W ( )**

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Age _____ **Date of Birth** _____ **Sex:** **Male ( )** **Female ( )**

Social Security # _____ **Drivers License #** _____

Email: _____

	Yes/No		Yes/No		Yes/No
Diabetes	( ) ( )	Stroke	( ) ( )	Seizures	( ) ( )
High Blood Pressure	( ) ( )	Elevated Cholesterol	( ) ( )	Glaucoma	( ) ( )
Elevated Triglycerides	( ) ( )	Thyroid Disease	( ) ( )	Heart Valve Disease	( ) ( )
Polycystic Ovarian Disease	( ) ( )	Sleep Apnea	( ) ( )	Heart Disease	( ) ( )
Do you smoke cigarettes?	( ) ( )	Psychosis	( ) ( )	Depression	( ) ( )
Are you breast feeding?	( ) ( )	Arthritis	( ) ( )	Substance Abuse	( ) ( )

Are you taking any type of Mao inhibitor (i.e. Nardil, Parnate)? ( ) ( )

Have you ever taken prescription weight loss medication? ( ) ( )

If yes, what type of medication? _____ When? _____

Have you been advised by your health care provider to lose weigh ( ) ( )

If yes, give providers name and address _____

List any health problems that you have in your family.	
Mother's Side of Family	**Father's Side of Family**

	Yes/No	List type of Allergies or Medications
Do you have any drug allergies?	( ) ( )	
Do you have any food allergies?	( ) ( )	
Are you taking any medications?	( ) ( )	
Have you been hospitalized in the last six (6) months?	( ) ( ) **If yes, describe**	

How did you hear about our weight loss center? Newspaper _____ Radio _____ TV _____ Friend _____ Other _____

By my signature below, I certify that the above medical information n this form is true to the best of my knowledge. I am not pregnant at this time, and should I become pregnant, I will stop my medication immediately, and inform this clinic and my healthcare provider of my condition. I am also aware that the provider here is not my personal medical physician and is generally not on call for emergency purposes. Furthermore, I acknowledge that in the last six (6) months I have received blood test including a CBC, Glucose Level, Thyroid Functioning Screen, Lipid Profile, Liver Functioning Screen and Serum Potassium Level,. I am not aware of any abnormalities on any of the tests and I have not been instructed by my family physician to refrain from weight loss medication. I give my full consent for the clinic to discuss my health with my healthcare provider. I authorize the clinic to release/obtain my records to/from other physicians.

I HEREBY RELEASE FROM LIABILITY THIS CLINIC AND IT'S PROVIDERS AND EMPLOYEES FOR ANY AND ALL INJURIES OR LOSSES THAT I MAY SUSTAIN AS A RESULT OF ANY MISREPRESENTATION THAT I MAKE IN MY MEDICAL HISTORY AND/OR PHYSICAL EXAM. I UNDERSTAND THAT THIS RELEASE FROM LIABILITY IS ON-GOING UNTIL SUCH TIME THAT I MAKE NECESSARY CORRECTIONS.

Signature _____ Date _____