



Name: _____ Birth Date: _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number: _____ Male / Female

Phone Number: _____ Alt. Phone Number: _____

Family/Primary Doctor: _____

Email Address: _____

How did you hear about us: (Please Circle One):

Website / Billboard / Printed Ad / Radio / Google Search / Other :

If a Friend – Please Print their Name _____

Past Medical History

Check all that apply and add any pertinent information.

- Diabetes Mellitus Last Hgb A1C _____
 Hypertension
 Elevated Cholesterol
 Heart Condition
 Coronary Artery Disease
 Congestive Heart Failure
 Arrhythmias
 Valvular Heart Disease
 Myocardial Infarction
 Stroke or other neurological condition
 Gallbladder Disease or Gallstones
 Liver Disease
 Peptic Ulcer Disease
 Kidney Disease
 Thyroid Disease
 Asthma Emphysema Chronic Bronchitis
 Blood Clots
 Cancer
 Anxiety Depression Other Psychiatric Disorder
 Bone Fracture in the last 6 months
 Pregnant or intend to become pregnant in the near future
 Breastfeeding
 Other Medical Condition not listed above

Past Surgical History: List all prior surgeries and dates.



Allergies

Please list all prescription or over-the-counter medication or food allergies and reactions that you have had to these products:

Medications

Please list all prescriptions and over-the-counter medications and doses:

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Social History

Marital Status

Children

Occupation

Tobacco Use

Alcohol Use

Illicit/Recreational Drug Use

 (Information strictly confidential)

Family History

Please note any medical problems and degree of obesity.

Father:

Mother:

Siblings:

Diet & Exercise History

Please list any diet programs used in the past:

Please list any prescription or over-the-counter diet medications used in the past:

What is your present activity level and exercise routine?
