

The Center for Medical Weight Loss
 405 Kiva Court Santa Fe, NM 87505
 (505) 988-8005 info@santafeweightloss.com

NEW PATIENT – MEDICAL HISTORY

Patient Name: _____

1. Please list any drug allergies or sensitivity: _____

2. Who is your primary care physician? _____
 Which city or town is his/her practice is located? _____

3. Please list any food allergies: _____

4. Do you have any of the following medical problems? (check all that apply)

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Diabetes
If yes, circle which: Type 1 or Type 2
<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer

If yes, type _____ | <input type="checkbox"/> Heart disease
<input type="checkbox"/> Arthritis

_____ Other _____

_____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|

5. Do you have any family history of medical problems? ___ Yes ___ No
Include in your answer the following: diabetes, high blood pressure, heart disease, cancer. If yes, please fill in the following:

Type of medical problem	Family member (mother, father, sibling)

6. Have you ever had surgery? ___ Yes ___ No
 If yes, please fill in the following:

Type of Surgery	Date (year)	Reason for surgery

Continued on back

7. Please list any chronic conditions that are currently treated by your primary care provider: _____

8. Are you currently taking anti-depressants? ___ Yes ___ No

9. Are you on appetite suppressants? ___ Yes ___ No If yes, which? _____
Have you taken in the past? ___ Yes ___ No If yes, when? _____

10. Please let us know about any medications you are currently taking:

Medication	Dosage	Reason for use	Prescribing doctor

11. Do you smoke? ___ No ___ < 1 pack per day ___ 1 pack or more per day

12. Do you drink? ___ No ___ Yes How many drinks per week? _____

13. Do you exercise? ___ No ___ Yes How many times per week? _____

14. What weight loss programs have you done previously? Check all that apply

- Weight Watchers
- Jenny Craig
- Medifast
- Other _____
- HCG
- Nutrisystem
- Optifast

15. Please indicate if any of the following apply so we can prescribe the best and safest weight loss program for you

- For women, are you pregnant or breast feeding?
- Do you have a pacemaker?
- Have you ever had an eating disorder?
- Do you suffer from severe stress or depression?
- Do you have history of drug or alcohol abuse?

_____ I understand that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I will report any changes in my medical condition to the office staff as soon as possible. The Center for Medical Weight Loss may notify your primary care physician if you enroll in a medical weight loss program. I have read the above questionnaire and acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions I may have made in completion of this form.

_____ I have additional health issues not addressed on this form.

Patient Signature

Date