

WEIGHT LOSS MEDICAL HISTORY FORM

Please complete and bring with you to the appropriate office, mail or fax:
(Or, you may complete this form at the office when you come for your appointment)

Physician Assisted Weight Loss, PLLC

6905 Fayetteville Road, Suite 201, Durham, N.C. 27713 Fax: 919.490.8890
110 U.S. Hgwy 321 SW, Hickory, NC. 28602 Fax: 828.326.7040

DATE _____

NAME _____

ADDRESS _____

CITY _____ State _____ Zip Code _____

Please only list phone numbers at which we may leave a message, if necessary.

() _____ () _____

E-mail address _____

Date of Birth _____

MARITAL STATUS S M DIV SEP W

OCCUPATION _____

DRUG ALLERGIES _____

MEDICATIONS

Smoker? ___yes ___no Drinker? ___yes ___no

Medical History/Chronic Medical Conditions

- | | | | |
|------------------------|---------------------|---------------------------|---------------|
| __ High Blood Pressure | __ Kidney Stones | __ Thyroid Disease | __ Narcolepsy |
| __ Diabetes | __ Asthma | __ Anxiety/Panic Disorder | __ Depression |
| __ Stroke | __ High Cholesterol | __ Exercise Restrictions | __ Glaucoma |
| __ Seizures | __ Angina | __ Drug Abuse | __ Bipolar |
| __ Cancer | __ Heart Attack | __ Anorexia/Bulimia | |

How did you hear about Physician Assisted Weight Loss?

Newspaper _____ Saw office sign _____ Friend recommended _____ Other _____