Seymour Weight & Wellness 216 Phoenix Court, Suite F Seymour, TN 37865 (865)573-0101

Name:	Gender: M / F	Date:
Address:		
City:	State:	Zip:
Phone Numbers: (1)	(2)	
Email:	Place of Employment:	
Date of Birth:	Age:	
Names of Medical Providers/Doctors:		Last Physical:
Referred by:	Height:	Weight loss goal weight:

For your best medical care, disclose all medical conditions and medications: Circle the ones that affect you

DIABETES		HIGH TRIGLYCERIDES		ANEMIA		ARTHRITIS		DEPRESSION		PRE-ECLAMPSIA or TOXEMIA	
HIGH BLOOD PRESSURE		ASTHMA		LIVER DISEASE hepatitis/cirrhosis		SINUS PROBLEMS/ ALLERGIES		ANXIETY		ADDICTIONS	
HEART ATTACK		EMPHYSEMA OR COPD		BLOOD CLOTS		SEIZURES		BROKEN BONES		IBS	
ANGINA OR CHEST PAIN		TB		GLAUCOMA		LUPUS		MUSCULAR PROBLEMS		CHRONIC PAIN	
ABNORMAL HEART RHYTHM		REFLUX		PROSTATE PROBLEMS		CHRONIC HEADACHES		DIABETES DURING PREGNANCY		ADD/ADHD	
HEART MURMUR		HEARTBURN		BLADDER or KIDNEY PROBLEMS		STROKES OR TIA'S		ANOREXIA or BULEMIA		SLEEP APNEA	
HIGH CHOLESTEROL		SPASTIC COLON		KIDNEY STONES		THYROID PROBLEMS		BIPOLAR DISORDER		LIST OTHERS:	

List ALL SURGERIES:

List ALL medication and over the counter supplements:

Are you ALLERGIC to medications or food items?

FAMILY HISTORY: Does anyone take medication for, or have:

HIGH BLOOD PRESSURE		BYPASS SURGERY/STENTS		HEART ATTACK OR HARDENED ARTERIES		STROKE, MINI -STROKE or TIA		CANCER:	
DIABETES		OBESITY		CHOLESTEROL or TRIGLYCERIDES		LIST OTHERS:			

Nicotine use per day? ______ How often do you drink alcohol? ________
PHARMACY USED: ________________________________

I have given truthful information and have not knowingly withheld ANY information that could affect the decisions in my health care.
I give permission to be treated appropriately by the staff of SWW. By signing, you also give SWW permission to electronically transmit necessary medical information for insurance and medical record keeping.

All controlled medication that is dispensed (Phentermine) is reported to the TN Board of Pharmacy as required by law.
We reference your controlled medication records from the TNBOP. Notify us if you have received controlled {diet pills, pain pills, anxiety pills or other) medications in the past year.

We will text you to remind you of your upcoming appointments or other correspondence, in accordance with HIPAA laws.

From time to time, we may contact you by email, text, phone or mail. Please indicate if you do not want us to contact you in this manner.

Our privacy policy is posted in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy will be provided upon your request.

SIGNATURE/DATE____