Doctor’s Orders Weight Loss Clinic

Weight Loss.... It’s what the doctor ordered!

Weight Loss History

Today's date:

Month Day Year

Date of Birth: *

Month Day Year

Name *

First Name Last Name

Age:

Cell Phone: *

Email *

example@example.com

How did you hear about us?

Google, yelp, current patient, friend, web search

In Case of Emergency:

Name: *

Relationship:

Phone: *

Family Physician:

Do you have allergies to any medications? *

List medication and reaction

ABOUT YOU:

Height: *

Current Weight:

Goal Weight:

Time Frame:

Average weight loss is usually 1-2 lbs per week.

CURRENT AND PAST MEDICAL HISTORY:

What is your general state of health?

Date of your last Physical:

Month Day Year

Are you on any medications (prescribed, OTC , or herbal supplement)? *

Please list names and how often taken

Do you have high blood pressure (higher than 140/90)? *

- ☐ Yes
- ☐ No

Please note that if blood pressure is found to be higher than 140/90, or any cardiac conditions are discovered on physical exam, amphetamine appetite suppressants are contraindicated. A medical referral will be given to control condition before starting weight loss medications.

Do you have diabetes? *

- ☐ Yes

☐ No

Do you have any breathing problems or shortness of breath? *

☐ Yes

☐ No

Do you have high cholesterol? *

☐ Yes

☐ No

Do you have a psychiatric history of? *

☐ Depression

☐ Bipolar Disorder

☐ ADHD

☐ Schizophrenia

☐ _____

Do you have a history of bulimia or anorexia? *

☐ Yes

☐ No

Previous surgeries or hospitalizations in the last 3 years?

If yes, please name them

Have you ever used any illegal drugs or controlled substance prescription medication that were not prescribed for you in the last 10 years? (Pain pills, weight loss pills, etc) *

☐ Yes

☐ No

If yes, explain:

Have you ever taken more controlled substance medication than the Doctor prescribed or taken pills

more frequently than precribed?

- [ ] Yes.
- [ ] No

If yes, explain:

Have you ever been arrested for drugs or admitted to drug rehab? *

- [ ] Yes
- [ ] No

If yes, explain:

FAMILY HISTORY:

Do you have a family history of:

- [ ] Hypertension
- [ ] Stroke
- [ ] Heart disease
- [ ] High cholesterol
- [ ] Obesity

DIET HISTORY:

Have you ever taken any prescription or OTC weight loss medications? *

- ◯ Yes.
- ◯ No

If yes, the name of the medication and the length of time used?

What is the most amount of weight you have lost and how did you lose it?

List any previous diets you have followed:

How often do you eat out at restaurants or fast food?

Do you exercise?

- ☐ Yes How often?:_____
- ☐ No

Do you lift weights?

- ☐ Yes
- ☐ No

WARNING:

Rapid weight loss may cause serious health problems. Rapid weight loss is defined as weight loss of more than 1 1/2 pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes such as making healthy food choices and increasing physical activity, promote long-term weight loss.