Weight Loss Intake Form

Email to: info@optimedspa.net

Name: _____ Date: _____ DOB: _____

Weight Loss Goal: _____

OTC Medications: _____

Have you gotten a Flu Vaccine this season? YES | NO

Have you traveled outside the US in the Past 30 days? Where? : _____

Any Medical Conditions? : _____

Prescription Medications : _____

Presferred Pharmacy : _____

Allergies to anything/Reaction : _____

Surgical History & Approx. Year : _____

Family History Immediate : _____

Social History

Smoke: Yes or No (If Yes how often?) : _____ Ecig: Yes or No:: _____

Drug Use: Yes or No (If Yes how often?) : _____ Preferred Drug:: _____

Drink: Yes or No (If Yes how often?) : _____ Caffeine: Cups Per Day:: _____

Exercise: Yes or No (If Yes how often?) : _____

(Office Use Only)

Vitals

Last Menstrual Period (First Day): ___/___/___ NA Pregnant? YES | NO How Many Weeks? _____

Height: Feet: _____ Inches: _____ Weight: _____

BP: _____/_____ mmHg | TEMP: : _____ F SpO2: _____ % Pulse: : _____ bpm

VISION R: _____/20 L: _____/20 | BOTH: : _____/20 Corrected | Uncorrected