OPTIONS
MEDICAL WEIGHT LOSS

OPTIONS for every BODY ™
OptionsMedicalWeightLoss.com

PATIENT QUESTIONNAIRE

Name: ______________________ DOB: ______________ AGE: ________

Height: __________ Weight: __________ Gender: ______________ Date: __________

How did you hear about us? ________________ If referred by someone, who? ________________

Please answer the following questions honestly so we can do our best to help you reach your goals:

What made you decide to do something about your weight today? ______________________________

Is there a specific program, or medication you are interested in? If yes which one? ______________________

Who encouraged you to lose weight? ________________ Can you commit to one visit a week? ____________

What important reason, special occasion, or goal date do you have for wanting to lose weight? ______________

How important to you is it that you lose weight? ______________________________

How many pounds would you like to lose? ______________ How fast do you want to be slim, trim, & fit? __________

Have you ever attended any other weight reduction centers, if so, which ones? ______________________

What kinds of diets have you tried on your own? ______________________________

What is the longest you've been able to stick with a diet? ______________________________

Does your family support your weight loss efforts? ______________________________

Have you been advised by your family physician to lose weight? ______________________________

Do you eat because of emotions?
If yes, please explain:

On average, which of the following reflects your daily eating habits? (Please check all that apply)

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Graze; small frequent meals
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs

Please check your current level of exercise:

- ☐ None
- ☐ Light exercise 1-3 times per week, easy pace, stretching, walking, etc.
- ☐ Moderate exercise 2-3 times per week, moderate pace, some weights, etc.
- ☐ Heavy exercise 3-4 times per week, vigorous pace, weights, fast running, etc.

Consult Notes:

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NEW PATIENT INTAKE

Name: ______________________________ Date: ____________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ________

Email address: ______________________________

Phone # (H) ____________ (W) ____________ (Other) ____________

Date of Birth: ____________ Gender: ____________ SS#: ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: ______________ Employer: ______________

Employer Address: ______________________________ Phone: ____________

Emergency contact: ______________ Relation: ______________

Phone # (H) ____________ (W) ____________ (Other) ____________

Please list any additional health complaints: ______________________________

Please list any surgeries (with dates) ______________________________

Please list any medical conditions (past & present) ______________________________

Family History: Please specify members of your family including extended family who have these illnesses.

Cancer: ______________ Hypothyroidism: ______________

Heart Disease: ______________ High Blood Pressure: ______________

Diabetes: ______________ Obesity: ______________

Current Medications/Prescriptions and Non-Prescriptions		
Prescriptions Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies (Medications & food) ______________________________

Some of out programs use medications that are not deemed safe to take while pregnant or breastfeeding.

Are you Pregnant, or breastfeeding? ☐ Yes ☐ No

Females Only: What was the first day of your most recent menstrual cycle? Date: ____________

Signature: ______________________________ Date: ____________

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HIPPA ACKNOWLEDGMENT AND CONSENT

I, the undersigned, acknowledge that I have had access to a copy of the NOTICE OF PRIVACY PRACTICES.
I consent to your disclosure, which you deem necessary in connection with myself or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Signature: ______________________________ Date: ______________________________

CONSENT TO TREAT

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL CARE

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at any facility that DBA Options Medical Weight Loss. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the medical treatments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature: ______________________________ Date: ______________________________

Parent/Legal guardian name: ______________________________

Guardian Signature: ______________________________ Date: ______________________________