

Lifestyle Weight loss Centers of Arizona

Please fill out the form below and fax or mail it to our clinic prior to your first visit

Date of Appointment: ____ / ____ / ____ Name: _____

dd / mm / yy (Last) (First) (Middle)

Date of Birth: ____ / ____ / ____ Sex: ____ M ____ F Age: ____ SSN: _____

dd / mm / yy

Address: _____

(Street number / P. O. Box) (Apartment number)

(City) (State/Province) (Postal Code)

(Home Phone) (Work Phone) (Fax)

(Email Address)

Occupation: _____ Full

Time ____ Part Time

Employer: _____

Are You: ____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

____ Living with a partner ____ Other

Emergency Contact: _____

(Name) (Relationship)

(Day Phone) (Evening Phone)

Primary Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder SSN: _____

Do you have children? ____ Yes ____ No If Yes, how many? ____

Where you injured on the job? ____ Yes ____ No

Are you pregnant? ____ Yes ____ No

For what are you being seen? _____

4700 S. McClintock Road Suite 105, Tempe, AZ 85282

Telephone: (480) 222-2198

Fax: (480) 730-1044

Lifestyle Weight loss Centers of Arizona

Referred By / How did you hear about our office?

When was your last physical?

(Month) (Year)

Who is your family physician?

(Name) (City)

When did you last visit a dentist?

(Month) (Year)

Who is your regular dentist?

(Name) (City)

Do you have a mercury fillings? ____ **Yes** ____ **No** If Yes, number of fillings?

When did you last visit an

optometrist? _____

(Month) (Year)

Who is your regular optometrist

(Name) (City)

Are you under the care of any specialists? **Yes / No**

(Name) (Specialty) (City)

Are you checking other health care? **Yes / No**

Please List your major health concerns in order of importance

Complaint Since Possible Cause(s)

3

Lifestyle Weight loss Centers of Arizona

What medications/supplements are you currently taking (prescription/over-the-counter/supplement/vitamins/mineral, etc?)

Medication/Supplement Since Adverse Effects

List all surgeries you have had:

Procedure Year Complications?

List any major injuries you have sustained:

Injury Year Long Term Effects

4

Lifestyle Weight loss Centers of Arizona

Which of the following conditions have you had? (Check all that apply)

Abscesses Depression Hepatitis Mononucleosis Rheumatic Fever Syphilis
Alcoholism Diabetes Herpes Genitalia Mumps Rubella Thyroid Disease

Allergies Emphysema High Blood Pressure Parasites Scarlet Fever Tonsillitis
Amnesia Epilepsy Influenza Pelvic Inflammatory Sexual Abuse Tuberculosis
Arthritis Gall Stones Kidney Disease Disease Skin Disease Typhoid
Asthma Gonorrhoea Leukemia Peritonitis Strep Throat Venereal Warts
Cancer Gout Malaria Pleurisy Sinusitis Whooping Cough
Chicken Pox Hay Fever Measles Pneumonia Sunstroke Worms
Cold Sores Heart Disease Miscarriage Prostatitis Stroke Yellow Fever

Which of the following do you currently use? (amount, how often, how much, how long?)

Alcohol _____ Tobacco

_____ Hormones _____ Coffee

_____ Cortisone _____ Laxatives

_____ Sedatives _____ Antacids

_____ Recreational Drugs _____

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home, or traveling?

Yes / No

Which of the following ailments listed, or any others, have affected your parents or siblings?

Alcoholism Depression Gallstones Hepatitis Osteoporosis Strep Throat
Allergies Diabetes Glaucoma Kidney Disease Pneumonia Stroke
Arthritis Easy Bleeding Gout Mental Illness Rheumatic Fever Thyroid Disease
Asthma Eczema Hay Fever Mononucleosis Skin Disease Tuberculosis
Cancer Emphysema Heart Disease Multiple Sclerosis Sickle Cell Venereal Disease
Chronic Epilepsy High Blood Pressure Anemia
Bronchitis

5

Lifestyle Weight loss Centers of Arizona

Any other medical conditions?

4700 S. McClintock Road Suite 105, Tempe, AZ 85282

Telephone: (480) 222-2198

Fax: (480) 730-10443