WINNING OVER WEIGHT

Patient Name: ______________________________________

Date of Birth: ______ / ______ / _________ Sex: ▫ Male ▫ Female

Address:____

____
City, State , Zip

Phone (_____) _____ - ____________

Email: ____

Parent / Guardian Information – If applicable and patient is under 18 years of age
Name:
____

Date of Birth: ______ / ______ / _________ Sex: ▫ Male ▫ Female

If different than above:

Phone (_____) _____ - ____________

Address:____

____
City, State , Zip

Email:____

Medical History

Have you ever been diagnosed with:

_____ Kidney disease
_____Substance or alcohol misuse
_____Depression
_____HIV Infection/AIDS
_____Obesity
_____Obstructive sleep apnea (OSA)
_____Diabetes mellitus (DM), Type 1
_____Diabetes mellitus (DM), Type 2
_____Osteoporosis
_____Cancer
_____Asthma
_____COPD
_____Congestive heart failure (CHF)

_____Stroke
_____Heart disease
_____Alzheimer's disease/Dementia
_____Arthritis
_____Prediabetes
_____Diabetes, Type 1
_____Diabetes, Type 2
_____High blood pressure
_____Elevated cholesterol

Please list any other major health problems:

Please list any other issues (for example, trouble sleeping, leg cramps,stress, etc).

Please list the top 3 things you would like to improve about your health:

1.
2.
3.

Please list all vitamins you are taking

Please list any minor health problems

Please list all medications you are taking

Please list your favorite foods

Please list any important food preferences (eating vegetarian, gluten free, eating at fast food restaurants, etc)