PATIENT HISTORY AND CONTACT INFORMATION

Sex: ❑ Male ❑ Female DOB: ______________________________ Age: ______________________________

Title: __________ First Name: ______________________________ Last Name: ______________________________

Address: ____

City: ______________________________ State: ______________________ Zip: __________________

Home #: ______________________ Work #: ______________________ Mobile #: ______________________

Email: ____

MEDICAL HISTORY

Are you pregnant? ❑ Yes ❑ No
Are you breastfeeding? ❑ Yes ❑ No
Do you have a history of blood clots? ❑ Yes ❑ No
Have you ever suffered a stroke? ❑ Yes ❑ No
Do you have herpes? ❑ Yes ❑ No
Do you have cancer? ❑ Yes ❑ No
Do you have any allergies? ❑ Yes ❑ No

If so please list: ____

____

Do you suffer from or have a history of:
Anxiety ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Blood Pressure ❑ Yes ❑ No
Cardiac ❑ Yes ❑ No
Depression ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Thyroid Problems ❑ Yes ❑ No
Menopause ❑ Yes ❑ No

List your current medications:

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SURGICAL HISTORY

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OFFICE USE – TO BE FILLED IN BY STAFF

Treatment Advised: ____

Desired Treatment Goals: ____

Height: ______________ Current Weight ______________ Goal Weight __________ Blood Pressure: __________

% of body fat ______________ Total Fat ____________________ BMI ______________________________

Hip Measurement __________ Waist Measurement ____________ Left Thigh _________ Right Thigh ______________

NOTES: ____

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