MUHLENBERG
WEIGHT LOSS LLC

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PATIENT DEMOGRAPHIC FORM

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____

Date of Birth: _____

Address (street): _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

PCP: _____

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

Employment Information

Employer: _____

Emp. Status: (circle) Full Time Part Time Not Employed Self-Employed Active Military

Student Status: (circle) Full Time Student Part Time Student

Emergency Contact Information

Emergency Contact: _____ Relationship to You: _____

Phone: _____

Additional Information

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Island
☐ Asian ☐ White
☐ Black or African American ☐ Denied/ Refused to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Denied/ Refused to Report

Preferred Language: ☐ English ☐ Spanish ☐ Other:

Pharmacy Name: _____

Do you give Muhlenberg Weight Loss LLC permission to send invoices, appointments and reminders via Text and E-mail? (Circle One) Y N

_____ _____
Signature of Patient Date

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# of Children…	0	1	2	3	4	Other: ____
At this time, my exercise routine includes…	Activity:		Minutes:		Times/ week:	
My Current Stress level is…	None	Low	Medium	High		
My biggest stressor is…	Job	Relationship	Health	Other:		
My tobacco use is…	Current	Former	Never	Quitting		
My current alcohol use is...	None	Occasional	Weekly	Daily	A Problem	
My current recreational substance use is…	None	Type:	Frequency:			
My current TV/computer time per WEEK is…	Less than 7hrs	7 to 15 hrs.	Over 15 hrs.			
I have had a problem with drug or alcohol addiction in past…	No	Yes	Which?			

My weight at age 20 was _____ lb.

My Weight one year ago was:_____ lb.

The MOST I ever weighed (non-pregnant) was_____ lb.

My **worst** food habit is: _____

- I am a **stress** eater? Yes No
- I eat in the middle of the night? Yes No
- My significant other has a weight issue? Yes No N/A

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period: Yes No

- *If "Yes" complete the following:*

During these episodes I feel I have NO CONTROL over my eating	Yes	No
I eat during these episodes even when I am not hungry	Yes	No
During these episodes I feel embarrassed by how much I ate	Yes	No
During these episodes I feel disgusted with myself, or guilty afterward	Yes	No
In the past 3 months, I have sometimes made myself vomit to try to control my weight?	Yes	No

BEVERAGE: I **drink** the following routinely

Beverage	Number per day
Fruit Juice	
Coffee	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Soda	
Diet Soda	
Water	

Typical Meals for me include: (if "none", please note that)

Breakfast	Lunch	Supper	Snacks

I have done the following **weight loss programs** before:

Program	Year	Result

I have used weight loss medication before: No Yes If yes, which? _____
I am currently using weight loss products: No Yes If yes, which? _____

The person(s) closest to me support my intentions to do this program: No Yes Unsure

Long term, I would like to maintain my weight at _____lbs. (This is my "New Climate" weight)

I would like to be at my "New Climate" weight in _____ months

My Past Health History

Previous or Current Health **Conditions I have had** include: (check all that apply to you)

	High Blood Pressure		Depression		Sleep Apnea		Thyroid Problems
	Diabetes		Anxiety		Asthma		Gout
	Heart Disease		Suicidal Ideation		COPD		Arthritis
	Kidney Disease		Binge Eating Disorder		Acid Reflux		Fibromyalgia
	Chronic Leg Swelling		Anorexia Nervosa		Irritable Bowel/Colitis		Osteoporosis
	Bleeding Disorder		Bulimia		Fatty Liver		Urinary Incontinence
	Blood Clot		ADHD/ADD		Crohn's Disease		Polycystic Ovaries
	Anemia		Bipolar Illness		Ulcerative Colitis		Menopause
	Cancer		Alcohol/Drug abuse		Liver/Gallbladder disease		Pancreatitis
	Skin Conditions		Headache/Migraine		Stomach Ulcers		Other:
	Elevated Cholesterol		Pancreatitis		Constipation		Other:

If yes was checked to any of the above, please explain:

_____

_____

_____

_____

_____

Surgeries I have EVER had include:

Type	Date	**Type**	Date
1.		**4.**	
2.		**5.**	
3.		**6.**	

Hospitalizations, and/or Serious Injuries I have EVER had include:

Reason	Date
1.	
2.	
3.	

I am **allergic** to, or do not tolerate the following medicines:

None (circle if appropriate)	**3.**
1.	**4.**
2.	**5.**

Prescription **Medications** I CURRENTLY take are:

Medication Name	Dose and Frequency	**Medication Name**	Dose and Frequency
1.		6.	

2.		7.	
3.		8.	
4.		9.	
5.		10.	

Over The Counter **Medications and/or Supplements/Vitamins** I CURRENTLY take are:

Medication Name	Dose and Frequency	**Medication Name**	Dose and Frequency
1.		5.	
2.		6	
3.		7.	
4.		8.	

My **Family's Health** History (check all that apply)

Disease	**Father**	**Mother**	**Brother/Sister**
Heart Attack			
Diabetes			
Cancer			
Thyroid Cancer			
Obesity			
Stroke			
Psychiatric			
Other			

Symptoms I am **experiencing at this time**: (check all that apply)

	Unexpected Weight Loss/Gain		Ulcers/Wounds on feet		Sadness/Depression
	Swollen Glands		Calf or leg pain while walking		Suicidal Ideation
	Feeling Sick		Change in bowel habits		Anxiety/Nervousness
	Longstanding pain		Heartburn		New/unusual headaches

	Fever/Chills/Sweats		Abdominal Pain		Falling down
	Disturbance in Vision		Painful or trouble swallowing		Skin rashes
	Eye Pain		Nausea or vomiting		Unexplained hair loss
	Hearing Loss		Yellow skin/eyes		Changing moles
	Voice Change		Black tar/blood in stools		Drinking too much
	Not well rested after full night sleep		Abnormal Bleeding/ Bruising		Low sex drive
	Fainting Spells		Constipation		Swelling in legs/ ankles
	Rapid/pounding heart		Diarrhea		Unexplained lumps/masses
	Shortness of breath		Trouble Emptying Bladder		Women Only
	Chest Pain		Blood in urine		Vaginal discharge
	Cough		Painful urination		Pelvic Pain
	Blood in Sputum		Urinating too frequently		Breast Lumps
	Wheezing		Urinary incontinence		Nipple discharge
	Loud Snoring		Abnormal urge to urinate		Men Only
	Stop Breathing in Sleep		Joint Swelling		Erectile dysfunction

I have completed this past medical history form and declare that all information I have given is true and complete to the best of my knowledge.

_____ _____ _____

Signature Printed Name Date