WEIGHT LOSS CLIENT INFORMATION

Date:______________________________

Name:_____________________________________ **Date of Birth ______________**

Address:____

City:_________________________ State:_________________ Zip:____________________

Home Phone:(_________)_________-_____________

Work Phone:(_________)_________-_____________

Cell Phone: (_________)_________-_____________

E-Mail Address ____

Emergency Contact:___________________________________ Relationship____________

Home Phone:(_________)_________-_____________

Work Phone:(_________)_________-_____________

Cell Phone: (_________)_________-_____________

Social Security Number (For Lab work paperwork only) ________-______-___________

HEALTH HISTORY

CONFIDENTIAL

Patients Name________________________________ DOB_____________________

CONDITIONS Check conditions you have or have had in the past

☐ Alcoholism ☐ Cancer Type_________________ ☐ Chemical dependency ☐ Diabetes ☐ Heart Disease ☐ Hepatitis ☐ High Cholesterol ☐ Kidney Disease ☐ Liver Disease ☐ Thyroid Problems Type________________	**QUESTIONS:** First day of last menstrual cycle: ________________________ Are you pregnant or planning on becoming pregnant? _______________________ List Any Allergies: ________________________ ________________________	Medications: ________________________ ________________________ ________________________ ________________________ ________________________ ________________________ ________________________ ________________________

To be filled out by Womens Wellness & Aesthetics:

#1 DOS_________

Height:________ Weight:______________ BMI:______ Neck _______ Waist_______ Hips________

Blood Pressure: _________/_________ RX called:____

Notes____

#2 DOS__________

Height:________ Weight:______________ BMI:______ Neck _______ Waist_______ Hips________

Blood Pressure: _________/_________ RX called:____

Notes____

#3 DOS___________

Height:________ Weight:______________ BMI:______ Neck _______ Waist_______ Hips________

Blood Pressure: _________/________ RX called: ____

Notes____

Pharmacy:_______________________________ City:__________________

Phone Number:(___________)______________________