THIN Centers MD
Medical Weight Loss Made Easy

Patient Information Sheet

Today's Date: / /

General Information

Last Name: **First Name:**

Date of Birth: / / **Current Age** **Occupation**

Marital Status: S M D W **Gender:** Male Female

Address: **Home Phone:**

City: **Work Phone:**

State: **Cell Phone:**

Zip Code: **Email Address::**

Are you a former client? Y N **If yes, which location?**

Date of last visit? / /

Emergency Contact Information

Name: **Phone:**

Relationship:

Referral Source

How did you hear about us?

- ☐ Friend (Name_____)
- ☐ Co-worker (Name_____)
- ☐ Radio
- ☐ Groupon Ad / Internet Ad
- ☐ Internet Search
- ☐ Mail Invitation
- ☐ Phone
- ☐ Sales Rep
- ☐ Physician
- ☐ Email

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Medical History

Please indicate if you (self) or any blood relative has or has had any of the following conditions:

Relative	Self		Relative	Self	
		Abdominal Pain			Hemorrhoids
		Accident (major)			Hepatitis
		Alcoholism / Drug Addiction			High Blood Pressure
		Allergy (any)			High Cholesterol
		Anemia			HIV / Aids
		Anorexia			Hot or Cold Flashes
		Anxiety			Increased Urination
		Arthritis			Irritable Bowel Syndrome
		Asthma			Joint or Muscle Aches
		Bad Taste in Mouth			Jaundice
		Back Pain			Kidney Disease
		Excessive Belching or Bur			Liver Disease
		Bladder Problems			Lung Disease
		Bleeding			Memory Lapses
		Blood / Stones / Pus in U			Mental Illness
		Blood Transfusion			Nail or Cuticle Problems
		Bulimia			Nausea or Vomiting
		Chest Pain			Neurological Disorder
		Cancer / Tumor			Osteopenia / Osteoporosis
		Constipation			Pain or Burning with Urination
		Coughing			Palpitations
		Depression			Paralysis
		Diabetes			Pneumonia
		Dry Skin			Poisoning / Medication Overdose
		Eczema			Recent Change in Bowel Habits
		Epilepsy / Seizures			Recurrent Colds
		Fainting / Dizziness			Ringing or Buzzing in Ears
		Gall Stones			Rheumatic Fever
		Gland Problems			Sexually Transmitted Disease
		Gastritis			Sleep Problems
		Goiter			Shortness of Breath
		Gout			Sinus Trouble
		Hair Loss			Stomach / Intestine / Colon Disorder
		Headache / Migraine			Swollen Legs / Ankles / Feet
		Heartburn			Stroke
		Heart Disease			Thyroid Disease
		Tuberculosis			Unusual Thirst
		Vision Problems			Varicose Veins

Other Medical Problems:

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Surgical History & Hospitalizations

Surgical History:

Date	Operation

Hospitalizations:

Date	Illness / Injury

Family / Social History

Father Deceased Yes No **Age:** _____ **Cause of Death:** _____

Mother Deceased Yes No **Age:** _____ **Cause of Death:** _____

Do you smoke or use any tobacco products? Yes No

Do you use any illegal or street drugs? Yes No

How many hours of sleep do you get on an average night? _____

Do you work a night shift? Yes No

If so, how many nights per week? _____

Medications & Allergies

Medications *(list current medications)*

Name	Dose

Allergy History *(list any allergy you have had)*

Name

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Medications & Allergies (continued)

Vitamins, Minerals & Supplements *(list current supplements)*

Name

Diet & Activities

What is the lowest weight as an adult that you maintained? ____

Have you ever had an eating disorder? Yes No

What medications or supplements have you taken in the past in an attempt to lose weight? (list all)

What other diets have you tried in the past?

Select your activity level? Inactive Light Moderate Heavy Vigorous

What types of exercise do you do and how often?

Why are you having difficulty managing your weight?

☐ Overeating ☐ Slow Metabolism ☐ Eating wrong foods

☐ Stress Eating ☐ Not exercising enough ☐ Other: ____

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Diet & Activities (continued)

What are your problem meals?

☐ Breakfast ☐ Morning snack ☐ Brunch ☐ Afternoon snack

☐ Lunch ☐ Evening snack

What foods do you eat too much of?

☐ Carbohydrates ☐ Protein ☐ Sweets ☐ Fats ☐ Alcohol

How much did you weight at age 18? _____

Were you overweight as a child? Yes No

Do you feel out of control while eating? Yes No

If so, which foods? _____

If you have lost weight, and then regained, please indicate the 3 most important reasons for the weight gain:

☐ less exercise ☐ overeating at meals ☐ stress

☐ infrequent clinical visits ☐ socializing ☐ stopped weight checks

☐ lack of support ☐ depression ☐ lack of planning

☐ other _____

What do you believe will be of the most help to assist you in losing weight?

_____

_____

_____

Do you follow a special diet?

☐ No ☐ Kosher

☐ Low fat ☐ Low Sodium

☐ Diabetic ☐ Vegetarian

☐ Other: _____

Which meals do you regularly eat?

☐ Breakfast ☐ Morning snack

☐ Brunch ☐ Afternoon snack

☐ Lunch ☐ Evening snack

☐ Dinner

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Diet & Activities (continued)

Do you usually eat out or order food in? Yes No

How often? Daily Weekly Monthly Other

How is your food usually prepared?
(pick all that apply)

- ☐ Baked
- ☐ Broiled
- ☐ Steamed
- ☐ Poached
- ☐ Boiled
- ☐ Fried

What beverages do you drink daily and how much?

Water	☐	8oz glasses per day
Coffee	☐	cups per day
Tea	☐	cups per day
Soda	☐	12oz glasses per day
Beer	☐	12oz glasses per day
Wine	☐	6oz glasses per day
Mixed Drinks	☐	6oz glasses per day
Other	☐	8 oz glasses per day
Specify:	☐	

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