Medical Weight Loss Solutions
Health Assessment

FOR CONSULTANT USE:	
Email__________________________	**WEIGHT**_________
______ -______ **WKS**	**GOAL WT**_________
	LBS TO LOSE___________

I. PERSONAL INFORMATION

Date________________________ Email___________________________________

Name ____Home Phone _____________Cell______________________

Address ______________________________________Age__________ DOB _______________Marital Status________

City_________________________State_________Zip______________Occupation______________________________

How did you hear about us? Physician Referral_____ Newspaper_____ Store Sign ______ Friend Referral ______Other___

II. HEALTH HISTORY

1. Personal Physician _____________________________Date of Last Exam____________________________
2. Current Medications including vitamins/herbs____
3. Have you seen a renal specialist or kidney doctor? Y or N If yes, please describe briefly_______________________
5. Are you under a physician's care for any acute or chronic medical condition requiring treatment? Y or N
6. Have you had any major surgery within the last 3 months? Y or N
   If yes, please describe briefly____
7. Have you been hurt or injured requiring hospital or medical care in the past year? Y or N
   If yes, please describe briefly____

III. WEIGHT LOSS HISTORY

1. How long have you been thinking about losing weight? ____
2. How long have you been overweight? ______________Lowest Weight _________Highest Weight_________________
3. **What would you like to weigh? _______ Your Height? ____________**
4. Why do you want to lose weight? Self Esteem _____Upcoming Event _____ Health ______Look Better_______________
5. Previous methods of weight reduction and results____
6. Is your husband/wife/family member overweight? _______________Are they supportive of you losing weight?_______

IV. EATING HABITS

1. What are your favorite foods?____
2. Do you tend to eat more during the day or at night? ________________________________
3. Have you noticed a decrease in your concentration and memory? Y or N
4. Do you crave carbohydrates? i.e. bread, pasta, cereal, etc. Y or N
5. Do you have problems sleeping at night? Y or N
6. What areas of your body are you most concerned about in regards to your weight?
   Shoulders ___Upper back ___Stomach ___Lower back ___Hips ___Thighs ___Buttocks ___Other____
7. How many meals do you eat per day? __________________How many snacks?_______________________________
8. 6. On a scale of 1 to 10 (10 being the highest) how committed are you to losing weight? ___________________________

V. MEDICAL HISTORY

SECTION I

ANGINA PECTORIS relieved with nitro	Y or N	INTESTINAL DISORDERS:	
ANOREXIA or BULIMIA, active	Y or N	Chrohn's Disease (diagnosed)	Y or N
BLOOD DISORDERS:		Colitis	Y or N
Hemophila or Leukemia	Y or N	Ulcerative Colitis	Y or N
Porphyria	Y or N	Severe Ileitis	Y or N
CANCER, active within 1 yr (not skin)	Y or N	Colostomy or Ileostomy	Y or N
KIDNEY:		MULTIPLE SCLEROSIS	Y or N
Dialysis/Kidney failure/Uremia	Y or N	Ever had GASTRIC BYPASS	Y or N
SCHIZOPHRENIA, SEVERE BIPOLAR	Y or N	LIVER:	
PREGNANT or Breastfeeding	Y or N	Cirrhosis or Liver Disease	Y or N
HIV POSITIVE OR AIDS	Y or N	Hepatitis, active	Y or N
Extensive heart condition- repeated MI	Y or N	LUPUS	Y or N
EPILEPSY (uncontrolled)	Y or N	SPASTIC COLON (Diagnosed)	Y or N
		SKIN CANCER, active within 1 yr	Y or N

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SECTION II

Condition	Answer
ACTIVE ALCOHOLIC	Y or N
HYPERTENSION-3 or more meds	Y or N
CANCER (other than skin)	Y or N
CARDIOVASCULAR	
Post Stroke (Within 1 year)	Y or N
Cardiovascular Disease	Y or N
Abnormal readings on an EKG	Y or N
KIDNEY STONES (within 1 yr)	Y or N
ONE FUNCTIONING KIDNEY	Y or N
CHRONIC CONSTIPATION	Y or N
Peripheral Vascular Disease (circulatory disorder)	Y or N
Post M.I. (Heart Attack, episodes within yr)	Y or N
ULCER (in last 12 weeks)	Y or N
LIVER – Hepatitis nonactive within 1 yr	Y or N
GOUT/High Uric Acid	Y or N
INSULIN DEP. DIABETES TYPE 1	**Y or N**
DIABETIC TYPE II	**Y or N**
Oral Meds	**Y or N**
Diet Controlled	**Y or N**

SECTION III

Condition	Answer
PACE MAKER	Y or N
CORTISONE THERAPY	Y or N
ARTHRITIS	Y or N
LACTOSE INTOLERANCE	Y or N
ENLARGED PROSTATE OR	Y or N
DIFFICULTY URINATING	Y or N
GALL BLADDER DISEASE	Y or N
GLAUCOMA	Y or N
EPILEPSY (controlled)	Y or N
FIBRIOD CYSTS	Y or N
FIBROMYALGIA	Y or N
ASTHMA or Asthma Meds	Y or N
CELIAC DISEASE	Y or N
WILSONS DISEASE	Y or N
MAJOR SURGERY within the last 3 months	Y or N
HYPOTHYROIDISM	Y or N
HYPERTHYROIDISM	Y or N
MIGRAINES (diagnosed, uncontrolled)	Y or N
HIATAL HERNIA	Y or N
STOMACH SURGERY	Y or N
Ulcer - within 3 years	Y or N
Staple – within 2 years	Y or N
TAKING DIURETICS	Y or N
THROMBOPHLEBITIS	Y or N
MITRAL VALVE PROLASE	Y or N
IRREGULAR HEART BEAT	Y or N
SPASMS	Y or N
VEGETARIAN	Y or N

Are you currently on any of the following types of drugs:

Drug	Answer
Mood Elevating Drugs	Y or N
MAOI	Y or N
Blood Thinners	Y or N
Synthroid or Synthroid Type Med	Y or N
High Blood Pressure Medication	Y or N
Insulin	Y or N
Diuretics	Y or N
Antipsychotics	Y or N
Antiulcer	Y or N
Anticulvulsants	Y or N
Antianginas	Y or N

1. Please list any prescription or over the counter diet medications you have used in the past
____

2. Circle if allergic: Aspartame - Milk - Soy- Shellfish - Pineapple - Iodine - Tyramine - Chocolate – Sulfa - Gluten
   Other____________________________________

3. Has your physician advised that you lose weight or prescribed any specific diet restrictions for you?
   Please list here____________________________________

4. Is there any additional information you believe we should be aware of in considering you for this program?
____

I reviewed my responses and they are true to the best of my knowledge. I understand that this information is to be used to assist Medical Weight Loss Solutions (referred to herein as "MWLS"), in providing an effective dietary program and online support via newsletters and emails. I also understand MWLS will not provide medical treatment. I have been advised that it is important for anyone who has a health problem and wants to lose weight to consult a physician before starting this or any weight loss program. If I am taking medication, I understand that a weight loss program can affect my need for the medication. My physician may want to make changes in my treatment or medication. I agree to inform MWLS of any changes in my health status, physical condition, or medication. I take full responsibility for my actions and do not hold MWLS responsible in any way.

DATE__________SIGNATURE______________________________PRINT NAME__________________________

DATE__________SIGNATURE______________________________PRINT NAME__________________________
(Parent/Guardian if client is a minor)

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