# WEIGHT LOSS INSTITUTE OF BAHAMAS MEDICAL HISTORY FORM

## PLEASE PRINT CLEARLY

Patient Name: ______________________________ Date Of Birth: ____________ Age: ________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Telephone No.1: ______________ Telephone No.2: ______________ SSN: ______________

Email Address: ______________________________

Emergency Contact: ______________________ Phone: ____________ Relationship: ____________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Married [ ] Single [ ] Divorced [ ] Seperated [ ] Referred By: ______________________

Primary Care Doctor: ______________________________ Phone: ______________

Name Of Responsible Party: ______________________ Relationship To Patient: ______________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Telephone No.: ______________________ Social Security No.: ______________

Employer: ______________________________ Position: ______________

Address: ______________________________ City: ____________ State: ______ Zip ________

Telephone No.: ______________________ Social Security No.: ______________

Primary Insurance Co.: ______________________________ Effective Date: ____________

Policy Holder: ______________________ Policy No.: ______________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Secondary Insurance Co.: ______________________________ Effective Date: ____________

Policy Holder: ______________________ Policy No.: ______________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Age: ________ Sex: M: ____ F: ____ Height: ____________ Weight: ____________ Body Mass Index (BMI): ____________

At what weight would you feel comfortable to maintain? ______________________________

Allergies (Include medications such as lidocaine, antibiotics, sulfa, etc.): ______________________________

______________________________

Present Medications: ______________________________

______________________________

## PAYMENT POLICY

I agree to pay any balance not covered by my insurance company to Weight Loss Institute Bahamas. Any unpaid balance will be promptly paid on a timely basis. I authorize my insurance company to pay Weight Loss Institute Bahamas directly.

Signed (Patient): ______________________________ Date: ____________

Weight Loss INSTITUTE OF BAHAMAS

# WEIGHT LOSS INSTITUTE OF BAHAMAS MEDICAL HISTORY FORM

## GENERAL MEDICAL HISTORY

| **CARDIAC** | **YES** | **NO** | **GASTROINTESTINAL** | **YES** | **NO** |
|---|---|---|---|---|---|
| Heart Attack | | | Reflux ( heartburn / GERD ) | | |
| Coronary Artery Disease | | | Ulcers | | |
| Congestive Heart Failure | | | Hiatal Hernia | | |
| High Blood Pressure | | | Gallstones | | |
| Heart Arrhythmia | | | Hepatitis | | |
| Valvular Heart Disease / Murmurs | | | Inflammatory Bowel ( Crohn's / UC ) | | |
| High Cholesterol/ Triglycerides | | | Irritable Bowel Syndrome | | |
| Chest Pain in past 6 months | | | Constipation | | |
| Leg / Ankle Swelling | | | Cirrhosis | | |
| Deep Vein Thrombosis (blood clots) | | | **BLOOD** | | |
| Peripheral Vascular Disease | | | Abnormal Bleeding | | |
| Other: | | | Anemia | | |
| **PULMONARY** | | | **ENDOCRINE** | | |
| Sleep Apnea | | | Diabetes | | |
| COPD (Emphysema) | | | Hyperthyroid | | |
| Asthma | | | Hypothyroid | | |
| Bronchitis | | | Adrenal ( Cushing's ) | | |
| Other: | | | Other: | | |
| **ORTHOPEDIC** | | | **RENAL** | | |
| Chronic Back Pain | | | Urinary Stress Incontinence | | |
| Pain in Weight Bearing Joints | | | Kidney Stones | | |
| Gout / Arthritis | | | Kidney Disease | | |
| Fibromyalgia | | | Other: | | |
| Other: | | | **EMOTIONAL** | | |
| **NEUROLOGICAL** | | | Depression | | |
| Seizure Disorder | | | Anxiety | | |
| Stroke | | | Suicidal Attempts | | |
| Headaches | | | Bipolar Disorder | | |
| Other: | | | Eating Disorders (Binge) | | |

## SURGICAL HISTORY

☐ I have never had surgery.

| Type of Surgery | Reason for Surgery | Year |
|---|---|---|
| | | |

## SOCIAL HISTORY

| ALCOHOL | TOBACCO USE: | ILLICIT DRUGS: |
|---|---|---|
| | | |

Weight Loss INSTITUTE OF BAHAMAS



## WEIGHT LOSS HISTORY

Please describe your weight loss history below.

| Weight Loss Technique | | | | | | | |
|---|---|---|---|---|---|---|---|
| Year | How Much Did You Lose? | "On My Own" | Commercial Diet | Diet Supplements (e.g. Optifast) | High Protein/ Low Carb | Medication | Surgery |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Has any weight loss method worked well for you in the past? Yes: ______ No: ______

If Yes, please describe? ______________________________

______________________________

______________________________

## FAMILY HISTORY

| |
|---|
| |

I certify that this is my true medical history to the best of my knowledge.

Signed: ______________________________ Date: ______________