Sea Mist
MEDICAL WEIGHT LOSS

Sea Mist Medical Weight loss, INC.

Patient Health History

Name:_____

Address:_____**City**_____

State:____**Zip code**_____**Phone: (cell)** _____**(home)**_____

Date of Birth:_____**Occupation**_____

Emergency Contact Name:_____

Relationship_____**Telephone #**_____

Primary Care Physician:_____

E-mail address _____

Driver License #_____ **Exp. Date**_____

How much weight would you like to lose?_____

For the followings please circle Yes or No

Do you want us to leave message for you via email or phone? Yes No

Have you ever been in any medical supervised Weight loss program before? Yes No

Do you have any history of the following? Please circle (Yes or No)

A)	**Drug or Food Allergies**	**Yes**	**No**	**(if yes, what is it?)**
B)	**Latex allergies**	**Yes**	**No**	
C)	**Leg cramps**	**Yes**	**No**	
D)	**Headaches**	**Yes**	**No**	
E)	**Arthritis**	**Yes**	**No**	
F)	**Sleeping problems**	**Yes**	**No**	
G)	**Dizziness/Vertigo**	**Yes**	**No**	
H)	**Anxiety/Depression**	**Yes**	**No**	
I)	**Epilepsy/Seizures**	**Yes**	**No**	

J) High Cholesterol Yes No
K) Cancer Yes No
L) Heart Problems Yes No
M) Kidney or liver disease Yes No
N) Diabetes Yes No
O) Asthma Yes No
P) High blood pressure Yes No
Q) Low blood pressure Yes No
R) Are you pregnant or breastfeeding Yes No
S) When was your last menstrual cycle?_____
T) How many time/week do you exercise?_____
U) Major illness/ hospitalization within last 6 months Yes No
V) Have you ever had a substance abuse problem within the last 6 month? Yes No
W) Do you have Glaucoma? Yes No
X) Do you have a thyroid condition? Yes No
Y) Do you drink alcohol? Yes No
Z) Do you smoke? Yes No (if yes, how many pack per day)
AA) Family history of heart disease Yes No

Please list all current medications including vitamins that you are taking.

_____

_____

What are your food craving?_____

How did you hear about us? Internet____ yelp_____Facebook_____Clipper Magazine_____
Community Guide_____OC Monthly_____Friend's Name_____
Postcard_____ Drive by_____ Other_____

The above information is a true representation of my current health status.

If you suspect that you are pregnant, discontinue any medications dispensed by Sea Mist Medical Weight loss, Inc. Pregnant or nursing mothers should not be taking any of these medications.

Signature:_____ Date:_____

If PATIENT IS A MINOR (under 18 year old) parent or legal guardian must sign on his or her behalf.