LEAN MD
MEDICALLY SUPPORTED WEIGHT LOSS

The Better Weigh Center| 5826 Esplanade Drive Suite 102| Corpus Christi, TX 78414| P: 361-500-2898

HEALTH QUESTIONNAIRE

FOR OFFICE USE: Today's Date Appt. Time ☐ Initial Consult ☐ Trans/Sustain ☐ Restart

First Name Last Name

Phone Email

Emergency Contact Relation to Patient Phone

Primary Care Physician Phone

HOW DID YOU FIND US? ☐ Current Patient ☐ Doctor Referral ☐ Family Member ☐ Friend ☐ Coworker
☐ Internet ☐ Advertisement ☐ Other: _____ Referrer's Name:

CURRENT MEDICATIONS & DOSAGE

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No

SMOKING ☐ Current Smoker ☐ Former Smoker (Year Quit _____) ☐ Never Smoked

HEALTH HISTORY: Please check off if any of the following conditions that apply to you.

___Hypertension ___Cancer ___Thyroid Disease ___Kidney Disease ___Anemia ___Substance Abuse
___High Cholesterol ___Glaucoma ___Liver Disease ___Sleep Apnea ___Eating Disorders ___Heart Attack/Heart Disease
___Diabetes ___Seizures ___Gallbladder Disease ___Migraine ___Alcoholism ___Other (list):
___Psychiatric Illness (please describe):

If female, are you trying to get pregnant? ☐ Yes ☐ No Date of last menstrual period: Birth control methods:

CURRENT SYMPTOMS: Please check off if you are experiencing any of the following conditions.

___Anxiety ___Nausea ___Abdominal Pain ___Chest Pain ___Headaches ___Vision Changes
___Depression ___Vomiting ___Irregular Heartbeat ___Dizziness ___Eye Pain ___Seizures
___Constipation ___Other (describe):

WEIGHT HISTORY Your Current Weight _____ Your Ideal Weight _____
Your Weight 1 Year Ago _____ 5 Years Ago _____ 10 Years Ago _____ Highest _____ Lowest _____

What do you feel is the cause of your weight gain?

Have you tried to lose weight in the past? ☐ Yes ☐ No

Please indicate If you have ever tried a previous weight loss regime.

___Atkins Diet ___Body For Life ___Jenny Craig ___Weight Watchers ___Low Calorie ___Low Carb
___Blood Type Diet ___Diet Medications ___Jumpstart ___Zone Diet ___Low Sugar ___Low Fat
___Low Sodium ___High Protein ___High Exercise ___Other (list):

Have you ever taken appetite-suppressing medication? ☐ Yes ☐ No

CURRENT ACTIVITY LEVEL ___Sedentary ___Light Activity ___Moderate Activity ___Very Active
Most Common Exercise / Activity How Often?

Are you currently being treated for any health concerns?

Are there any other concerns you many have that are not mentioned above?

I have answered all of the above questions to the best of my knowledge.

Patient/Guardian Name Patient/Guardian Signature Date