Ageless Center
MEDICAL WEIGHTLOSS & MEDSPA

CONFIDENTIAL MEDICAL HISTORY

The following information is necessary for our counselors to determine your eligibility for the program and establish your needs during the weight loss period. Please answer all questions accurately to the best of your knowledge.

All information will be kept confidential according to HIPAA guidelines. Thank you.

I. PERSONAL INFORMATION

DATE: _____

Name: _____ Email: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Subscribe to occasional text messages with Ageless Specials? Yes __ No __

City: _____ State: _____ ZIP: _____ Age: _____ Birthdate: _____

Employer: _____ Occupation: _____

Spouse/Partner Name: _____ Employer: _____ Occupation: _____

HAVE YOU BEEN TO AGELESS BEFORE? Yes____ No____ If yes, when? _____

HOW DID YOU HEAR ABOUT AGELESS? PLEASE CHECK ONE: BE SPECIFIC

- ☐ Physician Referral — Name: _____ Phone #: _____
  Practice Name: _____ Location: _____
- ☐ Patient Referral — Name: _____
- ☐ TV Station — Name: _____
- ☐ Radio Station — Name: _____
- ☐ Print — Name: _____
- ☐ Social Media — Explain: _____
- ☐ Event/Health Fair — Explain: _____
- ☐ Other — Explain: _____

II. MEDICAL HISTORY

1. Primary Care Physician: _____ Date of Last Examination: _____
   Practice Name: _____ Location: _____ Phone: _____

2. Please List *ALL* Medications You Are *Currently* Taking (Including Birth Control Pills, Aspirin, Laxatives, Vitamins, Etc.)
   Please Include Dosage, Strength, And Frequency:
   _____
   _____
   _____
   _____

3. Have You Ever Taken ANY Of The Following? Steroids: Yes____ No____ Fertility Drugs: Yes____ No____
   Appetite Suppressants: Yes____ No____ Chemotherapy: Yes____ No____ Hormone Replacement Medication: Yes____ No____

4. Known Medication Allergies: _____

5. Other allergies/food sensitivities: _____

6. Are You Currently Under A Physician's Care For Any Medical Condition Requiring Treatment? Yes____ No____
   If Yes, Please Describe: _____
   _____

7. If You Have Had Recent Surgery, Explain: _____

8. What Other Surgeries Have You Had? (List Year) _____
_____

9. List Reasons (And Year) For Any Other Hospitalizations Or Major Illnesses: _____
_____

10. FEMALES: Are You Now Pregnant Or Breast Feeding? Yes____ No____ At what age did you get your first period: _____
When was your last menstrual period? _____ How long did it last? _____

11. Are You Currently On Any Specific Diet Prescribed or Recommended By Your Physician Or A Dietitian? Yes____ No____
Explain:_____
_____

12. Do You Use Tobacco Products? Yes____ No____ If So, What Type/How Often? _____

13. On average, how many days a week do you consume alcoholic beverage? 0 1 2 3 4 5 6 7
On average, how many alcoholic drinks do you consume at one time? 0 1 2 3 4 5 6 7 8 9 10+
What types of alcohol do you consume? Beer Wine Liquor Other

14. Do You Take/Use Recreational Drugs? Yes____ No____ If So, What Type/How Often? _____

III. PLEASE CHECK IF YOU HAVE HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING. (If Yes, Please Explain):

GASTROINTESTINAL
____GERD
(gastro esophageal reflux disease)
____IBS
(irritable bowel syndrome)
____Celiac
____gluten sensitivity
____heartburn
____ulcerative colitis
____Crohn's disease
____diverticulitis/osis
____dumping syndrome
____gastric bypass
____gastric banding
____gastric sleeve
____other bariatric surgery
____diarrhea
____constipation
____Hx of bowel blockage
____other

RESPIRATORY SYSTEM
____asthma
____COPD
(chronic obstructive pulmonary disease)
____emphysema
____chronic allergy/sinus problems
____sleep apnea
____other

LIVER AND GALL BLADDER
____hepatitis A /B/ C
____elevated liver enzymes
____cirrhosis
____jaundice
____gall bladder disease
____gall stones
____other

KIDNEY
____poor kidney function
____kidney stones
____kidney failure
____nephritis
____kidney/bladder infections
____other

REPRODUCTIVE SYSTEM
____fertility treatment
____premenstrual syndrome
____PCOS
(polycystic ovarian syndrome)
____hysterectomy
partial total
____hormone replacement therapy
____BPH
(benign prostatic hypertrophy)
____other

ENDOCRINE & HEMATOLOGY
____anemia
____anti-coagulant therapy
(blood thinners)
____diabetes mellitus type I
____diabetes mellitus type II
____ insulin dependent?
____hypoglycemia
____hypothyroid
____Hashimoto's syndrome
____hyperthyroid
____gout
____metabolic syndrome
____growth problem
____Adrenal insufficiency
____Cushing's syndrome
____Other

CARDIOVASCULAR
____arrhythmia
____hypertension
(high blood pressure)
____irregular pulse
____High cholesterol
____poor circulation
____CABG
(coronary artery bypass graft)
____MI
(myocardial infarction/heart attack)
____stents/angioplasty
____pacemaker/defibrillator
____atherosclerosis
____coronary artery disease
____stroke
____other

GENERAL
____cancer
surgery chemo radiation
____fluid retention
____arthritis
osteo rheumatoid psoriatic
____fatigue
____AIDS
____lupus
____fibromyalgia
____eczema
____plantar fasciitis
____recurrent infections
____psoriasis
____joint replacement surgery
____other

PSYCHOSOCIAL
____SAD
(seasonal affective disorder)
____OCD
(obsessive compulsive disorder)
____schizophrenia
____bi-polar disorder
____depression
____anxiety
____anorexia
nervosa bulimia other
____alcoholism
____drug
dependence addiction
____history of abuse
____difficult home environment
____other

NEUROLOGIC SYSTEM
____epilepsy/seizures
____stroke
____syncope/fainting spells
____neuropathy
____MS
(multiple sclerosis)
____brain injury
____brain or spinal tumor
____other

Patient Name: _____ Date: _____

IV. WEIGHT LOSS HISTORY

1. Current Weight: _____ Desired Weight:_____

2. Lowest Body Weight:_____ Highest Body Weight:_____

3. How Long Have You Been Overweight? _____

4. Has Your Physician Recommended That You Lose Weight? Yes____ No____

5. Is Anyone Else In Your Family Overweight? (Spouse, Parents. Etc.) _____

6. How Long Have You Been Thinking About Losing Weight? _____

7. a. What are your nutrition and fitness goals?

1. _____
2. _____
3. _____
4 _____

b. What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet or exercise program, supplement use, books, etc.

1. _____
2. _____
3. _____
4. _____

8. FOODS: Do You Feel That You Have Good Eating Habits? _____
Are there foods you avoid? _____
Are you a Vegetarian? Yes or No If Yes, please circle which foods you DO NOT eat: Chicken fish dairy eggs red meat

9. EXERCISE: Are you currently on an exercise program: Yes or No
If so, what specifically are you doing each day?
Sunday _____
Monday_____
Tuesday_____
Wednesday_____
Thursday_____
Friday_____
Saturday_____

Are you currently working with a trainer or coach? Yes or no If yes, who and when?_____

Have you ever played a sport? Yes or no If yes, which sport(s), when, and how long? _____
_____

10. Do You Drink Water? Yes____ No____ If So, How many ounces per day? _____

11. On average, how many hours do you sleep: Weeknights _____ Weekends _____

12. Are you stressed? Yes or No If yes, how stressed are you? Please circle

1	2	3	4	5
Not at all	A little	Moderate	Very	Extremely

How do you manage stress? _____
_____

13. Are You Having Any Physical Discomfort Associated With Your Weight? _____
_____

14. Is, Or Will Your Spouse/Partner Be Aware That You Are On Our Program? Yes____ No____ N/A____

15. Why Do You Want To Lose Weight? Check All That Apply:

____ Special Event ____ Career ____ Appearance
____ Birthday ____ Social Life ____ Personal Life
____ Anniversary ____ Recreation ____ Self
____ Health ____ Clothing ____ Other_____

16. What Do You Feel Are Your Primary Challenges/Obstacles In Maintaining A Healthy Lifestyle? _____
_____

17. Would You Describe Yourself As A: Check All That Apply

____Emotional Eater ____Boredom Eater ____Stress Eater ____Foodie ____Busy Bee (food is a nuisance)
____Couch Potato ____Overweight, But Healthy Habits

18. Are You Ready To Make The Commitment To Lose Weight? Yes____ No____

I Understand that The Above Information Will Be Kept Confidential And Is Accurate To The Best of My Knowledge:

Client Signature_____ Date_____

Counselor_____ Date_____

Release of Medical Records- If you would like us to send your medical information to your other healthcare providers.
I hereby give authorization for The Ageless Weight Loss and Wellness Center to release all pertinent information regarding my past medical history, lab results, and any other confidential chart information to:

_____
Physician Name or Medical Facility

_____
Physician or Medical Facility Address

_____ _____
Client Signature Date Witness Signature Date

May we contact you by email with informative materials helpful to your weight loss and weight management success, and special sales benefits of interest to you, our valued client? Your address will be held in strict confidence and never forwarded or sold to any other organization, required under the Privacy Act. ☐ YES ☐ NO

_____
Please Print Your E-mail Address Clearly