CLEAR CHOICE
AESTHETICS

WEIGHT-LOSS PATIENT PACKET

Today's Date: _____

Name: _____ DOB: _____

Address: _____

Phone Number: _____ email: _____

By which of these ways can we contact you?
☐ Phone ☐ Text ☐ email

Can we leave voicemails for you?
☐ Yes ☐ No

Do you want someone other than yourself to be able to receive your health information?
☐ Yes ☐ No
If yes, please answer the following:
Name of the person: _____
Their relationship to you: _____
Check the type of information they can receive:
☐ All medical information
☐ Limited to (please specify): _____

Emergency Contact
Name: _____
relationship to you: _____
Phone Number: _____

Who is your primary-care Doctor?
Name: _____
Phone Number: _____

Which is your pharmacy?
name: _____
Pharmacy phone (not the store phone: _____

Allergies

Do you have any allergies?
☐ Yes ☐ No
If yes, please list them below

_____ _____
_____ _____
_____ _____

Medical History

Which of these have you ever had (check all that apply):

☐ Any heart conditions

☐ Any Neurologic conditions
☐ Any lung or breathing problems
☐ Any Digestive problems
☐ Any Liver problems
☐ Any Kidney problems
☐ Diabetes or pre-diabetes
☐ Cholesterol problems
☐ Any thyroid problems
☐ Blood pressure (high or low)
☐ Anxiety or Depression
☐ Eating Disorder
☐ Any other psychiatric issues or diagnoses
☐ Any problems conceiving
☐ any problems with your cycles, with conceiving or pregnancies
☐ Any types of Cancer
☐ Any blood disorder
☐ Ever received blood or other blood products
☐ Any types of Cancer

How many times have you been hospitalized before? _____

Have you ever spent a night in the ICU?
☐ Yes ☐ No

What specialists have you ever seen?
_____
_____

Which of these surgeries or procedures have you ever had (check all that apply)?
☐ Gastric bypass
☐ Gastric banding
☐ Gastric sleeve
☐ Gall bladder
☐ Cosmetic surgeries
☐ Thyroid surgery
☐ Heart (including bypasses, valve replacements, pacemakrs, cardiac catheterization)
☐ Blood transfusions
☐ any other surgeries/procedures not mentioned:
_____
_____

Have you ever had a severe trauma?
☐ Yes ☐ No

Medications (list all current medications and dosages if you know them):
_____
_____
_____
_____

Social History

Have you ever used any tobacco or nicotine-containing products (smoking, vaping, chewing)?
☐ Yes ☐ No

Other than occasional social drinking, have you ever used alcohol?
☐ Yes ☐ No

Do you now, or have you ever, used recreational drugs or prescription meds for recreation?

☐ Yes ☐ No

List the drugs you have tried

_____

_____

Family History

Which of these have any family member ever had (check all that apply)? Write which family member in the space provided:

☐ Obesity _____
☐ Any heart conditions _____
☐ Any Neurologic conditions _____
☐ Any lung or breathing problems _____
☐ Any Digestive problems _____
☐ Any Liver problems _____
☐ Any Kidney problems _____
☐ Diabetes or pre-diabetes _____
☐ Cholesterol problems _____
☐ Any thyroid problems _____
☐ Blood pressure (high or low) _____
☐ Anxiety or Depression _____
☐ Eating Disorder _____
☐ Addiction _____
☐ Any other psychiatric issues or diagnoses
☐ Any types of Cancer

_____ _____

Signature Date

_____

Print name