Today's Date	Patient I	History Form	ID Verified
Full Name		DOB	Height
Address			
Phone		E-Mail	
May We Contact You	ı Via E-Mail?	Yes No	
Occupation/Employe	er	W	ork Phone
Primary Care Physicic	ın		
May We Send a Lette	r About Your Pro	ogress to Your Physic	cian? Yes No
Emergency Contact			
NamePhone		_ Relationship	
By signing below you cal information with p			and discuss your medi- ergency.
Signature			o.goo,.
Primary Insurance		122	
			(Required if Billing Insurance)
Subscriber Name		Subscriber	's DOB
How Did You Find Us?	Check all that	apply	
Radio Advertisement			
My Doctor Referred Me	Soi	meone I Know Inspired Me	
	Name		Name





## Do you have, or have you ever had or been treated for any of the following conditions?

	Please	Circle		Please	e Circle
Irregular Heart Beat ————	Yes	No	Diabetes ————	Yes	No
High Blood Pressure ————	Yes	No	Stroke —	Yes	No
Heart Disease ————	Yes	No	Sleep Disorder ————	Yes	No
High Cholesterol ————	Yes	No	Glaucoma ————	Yes	No
Thyroid Disorder ————	Yes	No	Lupus/Autoimmune Disease —	Yes	No
Hepatitis/Liver Disease ————	Yes	No	Fibromyalgia ————	Yes	No
Polycystic Ovarian Syndrome —	Yes	No	Lung Disease ————	Yes	No
Prostate Disease/Enlargement —	- Yes	No	Arthritis ————	Yes	No
Blood Clot/Pulmonary Embolus —	Yes	No	Depression/Anxiety ———	Yes	No
Steroid Use (for Athletic Performance)	Yes	No	Psychiatric Disorder ———	Yes	No
Breast Cancer—————	– Yes	No	Hysterectomy/ovaries gone	Yes	No
Uterine/Ovarian Cancer ———	Yes	No	Hysterectomy only ————	Yes	No
Testicular Cancer ————	– Yes	No	Oophorectomy (Removal of Ovaries	s) Yes	No
Other Cancer———	Yes	No			

What Type?

Please List ALL Current Medications:

## Family History:

Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
High Cholesterol	Yes	No
Obesity	Yes	No
Cancer	Yes	No

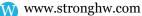
What Type





262-373-0169







Evor						
LVCI	Been	Prescribed an	Appetite Suppressant	Ś	Yes	No
le all	that	apply with an a	pproximate date last	taken	:	
Phentermine I				Diethylproprion		
		_ Qsymia	Belvique	S	axenda	
ory/H	Habits	:	Preventive Care:	Date o	of Last Exam	
Yes	No	Number per Day	Medical/GYN Exam			
Yes	No		Mammogram			
		Number per Day				
Yes	No		Bone Density			
		Number per Week	Pelvic Ultrasound			
				.,		
	-	-		Yes	No	
Je¢ _						
ever	beer	n on hormone re	eplacement therapy?	Yes	No	
oes						
	ory/H Yes Yes Yes	ory/Habits Yes No Yes No Yes No urrently on De? ever beer	Phendimetrazing Qsymia  Ory/Habits: Yes No Number per Day Yes No Number per Day Yes No Number per Week  Urrently on hormone replace?  ever been on hormone re	Phendimetrazine Diethylp	Phendimetrazine	Yes No Medical/GYN Exam Yes No Mammogram



