Today's Date_____ *Patient History Form* ID Verified_____

Full Name_____ DOB_____ Height_____

Address_____

_____

Phone_____ E-Mail_____

May We Contact You Via E-Mail? Yes No

Occupation/Employer_____ Work Phone_____

Primary Care Physician_____

May We Send a Letter About Your Progress to Your Physician? Yes No

---

Emergency Contact

Name_____ Relationship_____

Phone_____

By signing below you are giving us permission to contact and discuss your medical information with person listed in case of medical emergency.

Signature_____

Primary Insurance_____ SSN_____

(Required if Billing Insurance)

Subscriber Name_____ Subscriber's DOB_____

How Did You Find Us? Check all that apply

Radio Advertisement_____ Internet Search_____ Facebook_____

My Doctor Referred Me_____ Someone I Know Inspired Me_____

Name Name

STRONG HEALTH & WELLNESS

1285 Sunnyridge Road, Suite 101

Pewaukee, WI 53072

P 262-373-0169

W www.stronghw.com

E info@strongweightloss.net

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

	Please Circle			Please 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)	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

STRONG HEALTH & WELLNESS

1285 Sunnyridge Road, Suite 101
Pewaukee, WI 53072

P 262-373-0169
W www.stronghw.com
E info@strongweightloss.net

Do you have any medication or food allergies? Yes No

_____

Please List if Yes

Have You Ever Been Prescribed an Appetite Suppressant? Yes No

If *Yes,* circle all that apply with an approximate date last taken:

Phentermine_____ Phendimetrazine_____ Diethylproprion_____

Contrave_____ Qsymia_____ Belvique_____ Saxenda_____

Social History/Habits:

Caffeine Yes No _____ Number per Day

Smoking Yes No _____ Number per Day

Alcohol Yes No _____ Number per Week

Preventive Care: Date of Last Exam

Medical/GYN Exam _____

Mammogram _____

Bone Density _____

Pelvic Ultrasound _____

Are you currently on hormone replacement therapy? Yes No

If *Yes,* what type? _____

Have you ever been on hormone replacement therapy? Yes No

If *Yes,* what type? _____

Birth Control Method:

_____ Birth Control Pills

_____ Hysterectomy

_____ Menopause

_____ Tubal Ligation

_____ Vasectomy

_____ Other _____

STRONG HEALTH & WELLNESS

1285 Sunnyridge Road, Suite 101

Pewaukee, WI 53072

P 262-373-0169

W www.stronghw.com

E info@strongweightloss.net