Success Weightloss Systems Inc.
"Your Rapid Weightloss Resource"

TODAYS DATE:_____

PATIENT INTAKE FORM:

REFERRED BY? _____

Personal Information:

BLOOD TYPE _____

*Patient's First and Last Name: _____ DOB_____ Gender: M F

Mailing Address _____City:_____ State: _____ Zip: _____

Home Phone Number: _____ *Cell Number: _____ Work Number: _____

*E-Mail Address: _____ _____ Are you on facebook? Y N _____

Medical History:

Primary Care Physician_____ Phone Number: _____

When was the date of your last Physical? _____ * When did you have labs drawn last: _____ Where? _____

List any Prescriptions Medications you are currently taking: _____

_____

List any over the counter Medications that you are taking: _____

_____

Medication allegies_____

Are you allergic to Sulfur Medications? Y N Do you get Migraines? _____ Are you diagnosed with Depression? _____

Past Medical History:

List any current illnesses: _____

List any Illnesses in the last five Years: _____

_____

Past Surgical History: _____

List any Illness or Conditions: _____

_____

Women Only

Is there any chance you could be pregnant? ____ Do you plan on getting pregnant in the next 60 days? ____ Are you breast feeding? ____ Menopause ____

Date of last Period_____ Heavy or light _____ Are your periods regular ____ Length_____

Signature_____ Date_____

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CONSTITUTIONAL

Hot Flashes ___
Insomnia ___
Anxiety ___
Fever ___
Unexplained Weight loss ___
Unexplained weight gain ___
Chills ___
Fatigue ___

EYES

Blurred Vision ___
Double Vision ___
Glasses ___
Cataracts ___
Glaucoma ___

PULMONARY

Cough ___
Sputum/Phlegm ___
Shortness of Breath ___

EAR NOSE THROAT

Ear Aches ___
Nasal Drainage ___
Sore Throat ___

SKIN

Rashes ___
Easily Bruised ___

NEUROLOGICAL

Frequent Headaches ___
Blackouts ___
Contusions ___
Seizures ___

GASTRO INTESTINAL

Abdominal Pain ___
Ulcers ___
Black Bloody Stools ___

GASTRO URINARY

Problems Urinating ___
Frequent urination ___
Prostrate ___

CARDIAC

Heart Attack ___
Murmurs ___
Chest Pain ___

MUSKAL- SKELETAL

Back Pain ___
Joint Pain ___
Leg Pain ___
Ankle Swelling ___

PAST MEDICAL HISTORY

Diabetes IDDM / NIDDM ___
Hyperthyroidism ___
Hypothyroidisdm ___

SOCIAL HISTORY

Smoke ___
Alcohol ___

FAMILY HISTORY

Diabetes ___
Heart Disease ___
Cancer ___

DO YOU HAVE ANY OTHER HEALTH RELATED MATTERS WE SHOULD BE AWARE OF

_____
_____
_____

DO YOU HAVE OR HAVE YOU EXPERIENCED ANY EMOTIONAL CHALLENGES WE SHOULD BE AWARE OF THAT COULD ADVERSELY IMPACT YOUR OVERALL HEALTH OR YOUR WEIGHT LOSS EFFORTS? MENTAL ILLNESS OR EATING DISORDERS?

_____
_____
_____

ARE YOU EXPERIENCING MORE STRESS THAN USUAL? ARE YOU GENERALLY IN A HIGH STRESS ENVIRONMENT? HAVE YOU EXPERIENCED ANY LIFE-CHANGING EVENT THAT HAS CAUSED YOU TO EXPERIENCE ADDITIONAL STRESS OR GREIF?

_____
_____

Signature_____ Date_____