New Patient Intake form: Weight Loss

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MDVIP | AFFILITATED PRIMARY CARE

Name:_____
Address: _____
Cell Phone:_____
Email: _____
Primary Dr._____
Emergency Contact: _____

Date of Birth _____

Todays Date

MM DD YY

Please Answer All the Following:

Do you have any history (or family history) of:	Pancreatitis: Y N	Thyroid cancer: Y N
Do you have Diabetes: Y N	If yes:	Type 1 Type 2
Do you Smoke: Y N	If yes:	packs per week:
Have you been treated with any weight loss medication in the past? Y N	Which Med?	What Dose?
Do you Drink Alcohol: Y N	If yes:	How many drinks per week:
Do you have Obstructive Sleep Apnea: Y N	Do you have any form of Heart Disease: Y N	
Do you have:	High Cholesterol: Y N	High Blood Pressure: Y N
Please list any other medical conditions:	Name:	Name:
Do you have any allergies: Y N	Name:	Name:
Please list all supplements you are taking:	Name:	Name:
Please list all medications you are taking:	Name:	Name:
	Name:	Name:
Do you exercise regularly: Y N Do you check your heart rate during exercise: Y N	Do you follow a diet:	If yes, which one:

Signature _____

You can reach us at 716-236-8960 with questions/concerns. 7am to 5pm Monday-Thursday

Female Patients: please initial you are **NOT** currently or trying for pregnancy: _____

How did you how hear of this program:_____

I acknowledge the above medical history is, to the best of my knowledge, accurate and complete.
If I have any changes, I will notify the TMO Medical Providers at my next appointment without fail. If deemed advisable, I grant my permission for the TMO Medical Providers to contact my physician for details and advice.

Please be advised that payment is required prior to dispensing the medications