Carolina Physicians Weight Loss

New Patient Questionnaire

Date: _____

Name: _____ DOB: _____ Phone: _____Ok to contact by text? Yes No

Address: _____City: _____State: _____ Zip: _____

Email: _____ Gender: _____

Referred by: _____ Primary Care Dr & Ph# _____

Current Medical Conditions: _____

Do you or your immediate family members have a history of the following? Yes or No (circle & tell who)

Medullary Thyroid Cancer Y N Pancreatic Cancer Y N Multiple Endocrine Neoplasia 1 or 2 Y N

Pancreatitis Y N Diabetes Y N Heart/Cardiovascular Disease Y N Stroke Y N High BP Y N

Women: Are you pregnant or planning pregnancy or breastfeeding? _____

Current Medications Prescribed or OTC or Supplements/Vitamins: _____

_____

Allergies to medications: _____

Ideal Body Weight: _____lbs. Current Weight: _____lbs. Height: _____ft _____in

Have you experienced dieting in the past only to regain it? Y N

What diet programs have you tried? _____

What are you doing to lose or manage your weight?

OTC Medication Y N Prescription Medication Y N Physical Activity Y N Healthy Eating/Portion Control Y N

Intermittent Fasting Y N Other _____

What is your exercise routine and how often do you exercise?

_____

How much water do you drink daily? _____

What beverages and amounts do you drink daily? _____

Patient Signature: _____Date: _____