DR. MILNER'S *WeightWISE* PROGRAM
— PATIENT HISTORY—

Date: ________

1. Identifying information:

a. Name: ______________________________

b. Address: ______________________________

____

c. Social Security Number: ______________________________

d. Phone No: Home: ______________ Work: ______________

e. Personal Physician: ______________________________

f. Referral source: Newspaper: ______________________________

Magazine: ______________________________

Television: ______________________________

Radio: ______________________________

Other: ______________________________

g. Occupation: ______________ Usual hours: __________

h. E-Mail Address: ______________________________

2. Date of birth: ______________ Age: ______________

3. Sex: ______________ Marital Status: ______________

4. Current Height: __________ in. Current Weight: ______________ lbs.

a. Weight 2 years ago: ______________

b. Weight 5 years ago: ______________

c. Weight at age 18: ______________

8. Desired weight: ______________________________

9. Family history of obesity: ______________________________

10. Medical history:

Yes	No	
__	__	a. High blood pressure
__	__	b. Diabetes
__	__	c. Anemia

__ __ d. High cholesterol and/or triglycerides
__ __ e. Lung disease
__ __ f. Heart disease; chest pain
__ __ g. Arthritis
__ __ h. Emotional and/or psychiatric illness
__ __ I. Seizure disorder
__ __ j. History of drug abuse and/or addiction
__ __ k. Constipation/ diarrhea
__ __ l. Insomnia
__ __ m. Cigarette smoking
__ __ n. Alcohol consumption
__ __ o. Glaucoma
__ __ p. Depression
__ __ q. Hyperthyroidism
__ __ r. Pregnant or planning to get pregnant.
__ __ s. Other illnesses requiring medical care:

____

____

__ __ s. Medication currently being taken:

____

____

__ __ t. Allergies:

____

11. Eating history:

My usual breakfast consists of ____

____

My usual lunch consists of ____

____

My usual dinner consists of ____

____

My typical snacks are ____

____

Foods I do not like are ____

____

My worst eating habits are ____

____

12. Regular physical activities engaged in (type, frequency, duration): ______

____

13. Previous weight loss programs in which you have participated, amounts of weight lost, length of time weight was kept off: ____________________________

____

14. Why will this time be different than previous attempts? __________________

____

15. Do you have the support of family, friends, spouse? ____________________

____

16. Reasons for joining DR. MILNER'S program: __________________________

____

17. Then what? ____

____

18. Other comments or questions: ____

____

I hereby confirm that all information given is accurate to the best of my knowledge. Any incorrect or missing information could lead to harmful side effects from any weight loss medications prescribed to me. Any problems resulting form inaccurate information will be my sole responsibility.

Patient Signature____________________________________ Date ________________