PLEASE PRINT ALL INFORMATION CLEARLY: Today's Date _____

Full Name _____ Date of Birth _____

Street Address _____ City/State/Zip _____

Home Phone_____ Cell _____ Work _____

Occupation/Place of Employ _____ SS# _____

Spouse's Name _____ Primary MD _____

E-Mail: _____ Age _____ Height _____ Sex _____

Do you now have or have you ever been treated for any of the following:

	Yes	No
High Blood Pressure		
Heart Disease		
Lung Disease (eg: Asthma)		
Diabetes		
High cholesterol		
Kidney Stones		

	Yes	No
Depression		
Sleep Disorder		
Glaucoma		
Thyroid Disorder		
Hormones or Birth control		

Please List **ALL** Current Medications:

Medication/Dosage	Frequency

Medication/Dosage	Frequency

___ Please list any major surgeries you have had _____

___ Please list any other serious illnesses you have had _____

___ Have you ever had or been treated for alcohol or other substance abuse/dependence? _____

___ What would you like to weigh (goal weight)? _____ At what age were you last at that weight? _____

___ Any previous prescription weight loss medication? _____

___ Do you smoke? _____

___ Menses regular? _____ #Children _____ Are you pregnant? _____ Trying to become pregnant? _____

___ Any family history of: Heart Disease _____ Stroke _____ Diabetes _____

Cancer _____ High Cholesterol _____ Obesity _____

___ Do you exercise regularly? _____ How often? _____ Any problem with exercise? _____

___ Do you eat nutritiously? _____ Excessively? _____ Do you count calories? _____

___ Have you been overweight all your life? _____ If not, how long? _____

___ Any allergies to medicines including sulfur? _____ If yes, please list: _____

___ Do you take aspirin, ibuprofen, or naproxen? _____

Please list your preferred pharmacy: _____

Various researchers have estimated that one-fourth (1/4) of the United States population is hypothyroid, possibly as high as 40% may be hypothyroid.

Please check if you have any of the following physical and/or emotional signs of hypothyroidism:

	Weakness
	Dry, coarse skin
	Tired
	Swelling of face and eyelids
	Coldness and cold skin
	Diminished sweating
	Coarse hair
	Pale skin
	Constipation
	Gain in weight
	Loss of hair

	Labored, difficult breathing
	Swollen feet
	Hoarseness
	Loss of appetite
	Nervousness
	Heart palpitation
	Slow movement
	Poor memory
	Emotional instability
	Depression
	Headaches

_____ Please check here if none of the above apply

INITIAL EXAM (to be completed by clinic)

B/P	
Pulse	
Height	
Weight	
BMI	

Neck	
Chest	
Waist	
Hip	