SkinnyMe with HCG

# Patient Profile

Name_____ Date _____
Age_____Date of Birth_____ Sex: M F
Address_____
City, State, Zip_____
Cell #_____ Home #_____ Work # _____
Place of employment: _____
Best way to reach you: _____ Email _____
How did you hear about us? Please select all that apply:
Local magazine ad Word of mouth Social Network Physician referral Search engine
Business sign at location Other, please explain: _____
Name of Primary Care Provider: _____City & State_____

## Patient History & Physical

**Are you allergic to any medications?** Yes No
Name of medication and reaction:
_____
_____

**Prescription Drugs:**
(Please list all medication including any "as needed" medications, over the counter vitamins, and birth control)
Drug: Dosage: Frequency: Medical reason for taking prescription:
_____
_____
_____

Over the counter medication, vitamins, or supplements:
(Please indicate whether these items include any type of oil, i.e. sunflower seed, fish oil, etc.)
Product: Dosage: Frequency:
_____
_____
_____

**Please list all current medical problems:**
_____
_____
_____

**Medical History:**
Place a "C" for Current Condition
Place a "P" for Past Condition

___ Diabetes
___ Fatty Liver
___ Kidney Disease
___Fatigue
___Depression
___ Heart Disease
___ Anxiety
___ Eating Disorder
___Polycystic Ovarian Syndrome
___ High Cholesterol

Office Use Only

Height _____

Weight _____

Visceral _____

Abdominal _____

___Thyroid Disease
___ COPD/Emphysema
___ Liver Disease
___ Mental Illness
___ Snoring
___ Heart Attack

___ Hypertension
___ Bleeding Disorder
___ Alcohol Use
___ Osteoporosis
___ Fibromyalgia
___ ADD/ADHD

___ Cancer
Where?_____
Estrogen Fed? _____
___ Dumping syndrome related to surgery / gall bladder?
___ Vitamin D Deficiency

___ Smoking How Long? Quit? Y N
___ Alcohol Use How Often? _____

Gynecologic History:
Pregnancies: Number: _____ Dates: _____
**Last menstrual period**: _____ Are they regular? Yes No
Hormone Replacement Therapy: Yes No
**Birth Control:** Yes No Type:_____

**Surgical History:**
Have you had any surgeries? Yes No
Specify: (List all) Date
_____
_____

**Family History:** Age / Health / Disease / Overweight /Cause of Death
Father:_____
Mother: _____
Brothers:_____
Sisters:_____

Printed Name _____ Date_____

Signature _____

By signing this form you are confirming that all of the above information is true to the best of your knowledge. Your signature also confirms that prior to your initial consultation you have read and understand the Medical Disclaimer, Patient Consent, HIPPA compliance, and refund policy.