BE-LITE FOR LIFE MEDICAL CENTER INITIAL INTAKE FORM

A. Demographic information.

Item Requested **Answer**
Last Name, First Name, Middle Initial
Street City State Zip Code
Name, phone number (or city and state), of your primary care physician
State
Zip Code
Date of Birth (MM/DD/YY)
Are you an identical twin? YES_____ NO_____ Are you a fraternal twin? YES_____ NO_____ Have you had twins? YES_____ NO_____
Home Phone (including area code) Pager: Work Phone (including area code) Cellular Phone
Occupation
Referred by Person_____ Newspaper_____ Radio _____ TV _____ Yellow Pages _____ Internet_____
If you have ever smoked cigarettes Age of first use _____ Date of last use _____ Total years of use _____ Number of cigarettes/day currently _____

B. Please rate the intensity of any of the following symptoms you've had in the last week:

0 **0=No Problem**	**1** **1 = Minor Problem**	**2** **2 = Big Problem**
Hunger	Diarrhea	Rapid Heart Rate
Cravings	Constipation	Palpitations
Mood Swings	Hot flashes	Insomnia
Irritability	Dizziness	Anxiety
Headache	Dry mouth	Shortness of breath
Feeling "wired"	Blurred vision	Difficulty Urinating
Skin rash	Excess Urination	Excess Thirst

BE-LITE FOR LIFE MEDICAL CENTER MEDICAL HISTORY FORM

C. Additional items.

Item Requested	**Answer**
Age	Height (feet, inches) Highest weight ever
How many weight loss programs have you participated in? Please name them.	
How much alcohol do you drink per week?	What type of alcohol?
Have you ever used prescription diet pills before? (Yes or No)	
Have you ever used over-the-counter diet pills before? (Yes or No)	
What medicines are you **allergic** to?	
What **surgery** have you had	
Are you pregnant? _____ Do you take birth control pills?_____ When was your last menstrual period? _____ Are you breast feeding? _____	
Do you have a family history of diabetes, heart attacks or stroke?	
Do you exercise regularly? What kind of exercise do you enjoy? What do you do?	

Please check the list below if you currently have or have ever had any of these conditions.

Diabetes	Seizures
Thyroid problems	Heart problems/Palpitations
Stroke	High Blood Pressure
Back pain	Joint pain/Arthritis
Cancer	Hypoglycemia (low blood sugar)
Excess use of drugs or alcohol	Psychiatric Problems
Asthma	Glaucoma

Please list any medications you are taking?

It is important that you answer all the above questions. A blank answer will be assumed to be a no.

Signature_____ Date_____