New Patient Information

Envision Weight Loss Center

2701 Kirkwood Hwy
Wilmington, DE 19805
(302) 999-8465

Date:________________ Male Female

Patient Name:_______________________ DOB:____________

Address:____

City:______________________ State:__________ Zip Code:________________

Email Address:____

Home Phone:____________________ Cell / Work Phone: ____________________

Emergency Contact Name:____

Emergency Contact Phone Number:____

Family Physician:______________________ Phone:____________________

How did you hear about our weight loss program?

1) Referred by:____
2) Current Patient: Yes No
3) Other:____

I understand that even if this is NOT a covered benefit by my insurance plan and that I am financially responsible for all charges presented to me, which are to be PAID IN FULL at the time services are provided. [cost of diet programs vary depending on each individual's need]

Signed:__________________________________ Date:_______________________

Medical History

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes / No

2. Are you under a doctor's care at the present time? Yes / No
   If yes, for what? ____

3. Are you taking any medications at the present time? Yes / No

   Name of Medication:_________________________________ Taken for:_______________
   Name of Medication:_________________________________ Taken for:_______________
   Name of Medication:_________________________________ Taken for:_______________
   Name of Medication:_________________________________ Taken for:_______________
   Name of Medication:_________________________________ Taken for :_______________

4. Do you have any allergies to any medications? Yes / No
   If yes, what?____

5. Do you have history of:
   High Blood Pressure Yes / No
   Diabetes Yes / No
   Heart Attack Yes / No
   Chest Pain Yes / No
   Swelling of Feet or Hands Yes / No
   Frequent Headaches Yes / No
   Migraines Yes / No
   Constipation Yes / No
   Glaucoma Yes / No

Gynecologic History:

1. Pregnancies: (number)___________________

2. Menstrual Cycle: Are they regular? Yes / No
   Last Menstrual Cycle:_______________
   Menopause Yes / No
   Hysterectomy: Yes / No

3. Birth Control Pills: Yes / No
   If yes, what type:_______________________________________

Serious Injuries: Yes / No

Specify:___________________________ Date:_______________

Surgeries Yes / No

Specify:________________________________ Date:__________________
Specify:________________________________ Date:__________________
Specify:________________________________ Date:__________________

Family History:

1. Does your father, mother, sister, or brother suffer from any of the following:

		Who?
Heart Disease	Yes / No	__________________________________
High Cholesterol	Yes / No	__________________________________
Diabetes	Yes / No	__________________________________
Cancer	Yes / No	__________________________________
Obesity	Yes / No	__________________________________

2. Has any <u>blood relative</u> have any of the following:

		Who?
Glaucoma	Yes / No	____________________________________
Asthma	Yes / No	____________________________________
High Blood Pressure	Yes / No	____________________________________
Kidney Disease	Yes / No	____________________________________
Diabetes	Yes / No	____________________________________
Tuberculosis	Yes / No	____________________________________
Heart Disease/Stroke	Yes / No	____________________________________
HIV / Hepatitis	Yes / No	____________________________________

Past Medical History: (check all that apply)

____ Polio	____ Measles	____ Tonsillitis
____ Jaundice	____ Mumps	____ Pleurisy
____ Kidney disease	____ Scarlet Fever	____ Liver Disease
____ Lung Disease	____ Whooping Cough	____ Chicken Pox
____ Rheumatic Fever	____ Bleeding Disorder	____ Nervous Breakdown
____ Ulcers	____ Gout	____ Thyroid Disease
____ Anemia	____ Heart Disease	____ Tuberculosis
____ Gallbladder Disorder	____ Psychiatric Illness	____ Drug Abuse
____ Eating Disorder	____ Alcohol Abuse	____ Pneumonia
____ Malaria	____ Thyroid Fever	____ Cholera
____ Cancer	____ Blood Transfusion	____ Arthritis
____ Osteoporosis	____ Other:________________________	

Weight History:

1. Present Weight:__________________Height:________________ Desired Weight:_______________

2. What is the main reason for your decision to lose weight?
   ____
   ____
   ____
   ____

3. When did you begin gaining excess weight? (If known, give reasons)
   ____
   ____

4. What has been your maximum lifetime weight (non-pregnant) and when?________________________

5. Previous diets you have followed: Results of weight loss:

Previous diets you have followed:	Results of weight loss:
____________________________________	____
____________________________________	____
____________________________________	____
____________________________________	____

Psychosocial History:

1. Is your spouse, fiancé', or partner overweight? Yes / No

2. Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle your choices)

   Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s)

   Other:_________________________________

3. Who do you feel may not be supportive of your weight loss and changes in lifestyle? (circle your choices)

   Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s)

   Other:________________________

4. List five reasons you think it is important for you to lose weight. Please number the reasons, with "1" being the most important.

   1. ____
   2. ____
   3. ____
   4. ____

5. ____

Lifestyle and Eating Habits:

5. How often do you eat out?____

6. How often do you eat "fast foods"?____

7. Are you allergic to:
   Cocoa? ☐ Yes ☐ No
   Milk protein? ☐ Yes ☐ No
   Corn? ☐ Yes ☐ No
   Soy? ☐ Yes ☐ No
   Eggs? ☐ Yes ☐ No
   Other food? (describe) :____
   ____

8. Food Dislikes:____

9. Food you crave:____

10. Do you drink coffee or tea? Yes / No How much daily?___________________________

11. Do you drink cola drinks? Yes / No How much daily?___________________________

12. Do you drink alcohol? Yes / No
    How much?____________________ Frequency?____________________

13. Do you awaken hungry during the night? Yes / No
    What do you do?____

14. What are your worst food habits?____
    ____

15. Do you snack? Yes / No
    On What? ____
    ____

16. When you are under a stressful situation at work or if it is family related, do you tend to overeat?
    Yes / No

Smoking Habits: (answer only one)

_______ You have never smoked cigarettes, cigars, or a pipe

_______ You quit smoking ________ years ago and have not smoked since

_______ You have quit smoking cigarettes at least one year ago and now smoke electronic cigarettes

_______ You smoke < ½ pack of cigarettes per day

_______ You smoke < 1 pack of cigarettes per day

_______ You smoke _______ cigarettes per day

Activity Level: (answer only one)

_______ **Inactive** = no regular physical activity with sit-down job

_______ **Light Activity** = no organized physical activity during leisure time

_______ **Moderate Activity** = occasionally involved in activities

_______ **Heavy Activity** = consistent physical activity

_______ **Vigorous Activity** = participation in extensive physical exercise for at least 60 min 4 times per week

Typical Breakfast:

____

____

____

____

Time eaten:________________

Where:_____________________

With Whom:_______________

Typical Lunch:

____

____

____

____

Time eaten:________________

Where:_____________________

With whom:________________

Typical Dinner:

____

____

____

____

Time eaten:__________________

Where:_______________________

With whom:__________________

Please describe your general health goals and improvements you wish to make:

____

____

____

____

____

This information will assist us in assessing your particular problem areas and establishing your medical weight loss and management. Thank you for your time and patience in completing this form.

Weight Loss Consumer Bill of Rights

Envision Weight Loss Center
2701 Kirkwood Highway
Wilmington, DE 19805

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week, or weight loss of more than 1 percent of body weight per week after second week of participation in a weight loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. The patient is under no obligation whatsoever, to purchase medication and supplements form Dr. Krasner. Meal replacements such as protein shakes and bars and vitamins are sold for profit.

You as the patient have the right to:
Ask questions about the potential health risks of the program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory test; and know the actual or estimated duration of the program.

I have read and understand the above:

____
Patient Name (print)

____ ____________________________
Patient Signature Date