Island Weight Clinic, Inc.
1600 Sarno Road, Suite 17 Melbourne, FL 32935
321-259-8446

1450 N. Courtenay Pkwy, Suite 3 Merritt Island, FL 32953
321-453-2410

Personal Health History

PERSONAL INFORMATION

Full Name: ____

Home Phone: ______________________________ Cell Phone: _______________________________

Email Address: ____

Home Address: ____
City:____________________________ State: ___________________ Zip Code: ________________

Age: _______ Date of Birth: _______________ Height: ______ft ______in Weight: ________________

Place of Employment: _____________________________________ Phone: _____________________

Emergency Contact: _____________________________ Phone: ______________________________

Referral/How Did You Hear About Us? ____

HEALTH HISTORY

1. Personal Physician: ____________________________________ Phone: ___________________
Date of Last Exam: ____

2. Are you under a physician's care for any acute or chronic medical condition requiring treatment? Yes/No

3. Please list and date all surgeries: ____
____

4. Have you been hospitalized within the last year? Yes/No
If yes, please explain: ____

WEIGHT LOSS HISTORY

1. Previous methods of weight reduction and results:
____

2. Have you taken weight loss medication in the past? _______________________________________

3. Have you had gastric bypass or lap band? ____

4. What is your desired weight? ____

5. What method of exercise do you use? ____
How often? ____

MEDICAL HISTORY

Please list allergies: ____

Please list all medications and dosage now being taken (including vitamins and herbal products):
___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

ANGINA	Y or N	KIDNEY CONDITIONS	Y or N
ANOREXIA OR BULIMIA	Y or N	GLAUCOMA	Y or N
BLOOD DISORDERS	Y or N	LIVER CONDITIONS	Y or N
CANCER, ACTIVE W/IN 1 YEAR	Y or N	LUPUS	Y or N
EPILEPSY	Y or N	ASTHMA	Y or N
SEIZURES	Y or N	HEADACHES	Y or N
STROKE	Y or N	FAINTING	Y or N
GOUT	Y or N	IRREGULAR HEATBEAT	Y or N
HIV POSITIVIE OR AIDS	Y or N	PALPITATION	Y or N
DIABETES	Y or n	HYPERTENSION	Y or N
INSULIN DEPENDENT	Y or N	NERVOUS BREAKDOWN	Y or N
ULCER	Y or N	DIFFICULTY SLEEPING	Y or N
INTESTINAL DISORDER	Y or N	HEART CONDITIONS	Y or N
THYROID CONDITION	Y or N		

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAN:

____

____

____

DO YOU DRINK ALCOHOL?
If yes, how often? ___________

ARE YOU PREGNANT OR BREASTFEEDING?
If yes, which one? ___________________

____

Signature: ____

Date: _________________________