

slenderkare Weight Loss & Wellness Plan Patient Information

(All information is strictly confidential and becomes part of your medical record on file)

Name: (Last) _____ (First) _____ (MI) ____ Gender: **M** **F**

Home Mailing Address: _____

City: _____ State: ____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Driver's License _____ Social Security # _____ Birth Date: _____ Age: ____

Occupation: _____ Place of Employment: _____

In Case of Emergency:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Spouse/Partner: _____ Phone: _____

Primary Care Physician: _____ How did you hear about us? _____

Financial Policy:

Thank you for selecting *skinkare, Ltd and Dr. William Drury, MD* for your health care needs. We are honored to be of service to you. Please be advised that payment for services is due at the time services are rendered, unless prior arrangements have been made. We accept cash, debit cards, Visa, MasterCard and American Express. We do not file or accept insurance. Sorry, no checks on initial visit. We do not offer refunds on any services or products, so we urge you to be certain of your decision before paying. 24-hour notice for cancellation is required to avoid any fees.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature _____ Date _____

Medical History

Last Physical: _____ Last EKG: _____ Last Eye Exam: _____ Last Lab: _____

Results/Comments: _____

Medication Allergies: _____ Do you use tobacco products? _____

Are you presently under the care of a physician (please list condition and treatment)? _____

What commercial diet plans have you tried? _____

What OTC or prescription diet medications have you taken? _____

Please list all medications that you are presently taking? _____

Any personal history of the following:

- | | | | | |
|--|--|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Gallbladder/Liver Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Gynecology Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Leber's |

Are you pregnant or breast-feeding? ____ Trying to get pregnant? ____ Date of last menstrual period? _____

How do you view your present level of physical activity? _____

How do you view your present dietary intake? _____

What would you select as your desired weight or clothing size? _____

I vow that the information contained in this medical questionnaire is accurate to the best of my knowledge.

(Signature of patient or authorized person completing this form) _____ Date _____