

# Clarkston Medical Group Weight Management Program Patient Application

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Phone Home \_\_\_\_\_  
Work \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Present Weight \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

Contract Number \_\_\_\_\_

**WEIGHT HISTORY:** To the best of your recollection, what was your weight:

One year ago \_\_\_\_\_ Five years ago \_\_\_\_\_

**FAMILY HISTORY:** Have your parents, brothers or sisters had:

	Yes	No		Yes	No
Diabetes	____	____	Coronary Heart Disease	____	____
High Blood Pressure	____	____	Obesity	____	____

**MEDICAL HISTORY:** Do you have any of the following conditions or symptoms:

	Yes	No		Yes	No
Diabetes	____	____	Shortness of breath	____	____
Kidney disease	____	____	Swelling of legs	____	____
High blood pressure	____	____	Back pain	____	____
Missing menstrual periods	____	____	Falling asleep at odd times	____	____

Are you now or have you ever been under psychiatric care? \_\_\_\_\_

What methods of weight control have you previously tried?

Diet alone \_\_\_\_\_ Medications \_\_\_\_\_ Surgery \_\_\_\_\_ Group programs \_\_\_\_\_

List all medications that you are presently taking: \_\_\_\_\_

\_\_\_\_\_

Why do you want to enroll in this program? \_\_\_\_\_

\_\_\_\_\_

What concerns do you have about your ability to be successful in this program? \_\_\_\_\_

\_\_\_\_\_

Do you foresee any financial hardships by being in this program? \_\_\_\_\_

\_\_\_\_\_

Do you have any questions about the program? (please write on back of this form)