Print Form

Sun Valley Weight Management Clinic, LLC
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REGISTRATION FORM *PLEASE PRINT*

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	☐ Mr. ☐ Mrs.	Marital status (check one)		
Address:		☐ Miss ☐ Ms.	Single ☐ Ma ☐ Div ☐ Sep ☐ Wid ☐		
City:	State:	Zip:	Birth date:	Age:	Sex: ☐ M ☐ F
Additional Address *(if needed)*:	Street:	City:	State:	Zip:	
Home Phone #:	Cell #:	Work #:			
Phone # we should use 1st to contact you (circle one): Home ☐ Cell ☐ Work ☐		Email:			
How did you hear about us: ☐ Yellow pages ☐ Business Card ☐ Friend ☐ Newspaper ☐ Other (please write in):					
Referred to our clinic by:	Name:	Do you or any family members have Leber's Optic Neuropathy? ☐ Yes ☐ No			
SOCIAL HISTORY	Do you use alcohol? ☐ Yes ☐ No	Do you use tobacco? ☐ Yes ☐ No			
	Do you use drugs? ☐ Yes ☐ No ☐ In the past	If so, what drugs?			
HEALTH HABITS	Have you been overweight since: ☐ Childhood ☐ High School ☐ 3 or more years ☐ 1-2 years ago				
Are you on a diet? ☐ Yes ☐ No	Name of prescribed DIET and/ or medications, if any:				
HEALTH HISTORY	*WOMEN ONLY*	Last period	Menopause ☐ Yes	Are you pregnant or planning to get pregnant? ☐ Yes ☐ No Are you currently breast-feeding? ☐ Yes ☐ No	
Exercise Habits (check one):	Sedentary (no exercise)	Mild exercise	Regular vigorous exercise		

QUESTIONS CONTAINED IN THIS QUESTIONAIRE WILL BE KEPT STRICKTLY CONFIDENTIAL AND ARE PART OF YOUR MEDICAL RECORD.

MEDICAL HEALTH HISTORY

Do you have any medical problems? ☐ Yes ☐ No *Please answer all questions and fill in "Other" if necessary	Cancer ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	
	Thyroid ☐ Yes ☐ No *Please circle one:* Hypo or Hyper	Heart disease ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	
		Pacemaker ☐ Yes ☐ No	Depression ☐ Yes ☐ No	
	Seizures ☐ Yes ☐ No	Heart Valve problem ☐ Yes ☐ No	Bipolar ☐ Yes ☐ No	
	Headaches ☐ Yes ☐ No	Other:		

SURGERIES	Have you had surgeries?	☐ Yes ☐ No	If yes, explain	
MEDICATIONS	Are you allergic to any medications?	☐ Yes ☐ No	If yes, explain	Are you taking: Pamate? ☐ Yes ☐ No Marplan? ☐ Yes ☐ No
Are you taking any medications?	☐ Yes ☐ No	***Please list the medications & supplements you are taking on next page**		

FAMILY HEALTH *Please fill in ALL lines Write "healthy" if no health issues. Please write "deceased" where necessary.	Family Health problems	Mother	Brothers
		Father	Sisters
		Grandparents	Children
			Other:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone #:	Work / Cell phone #:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient Signature: _____ Date: _____

Guardian signature (if required): _____ Date: _____

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***Please list the medications & supplements you are taking**