THE TRIM TEXAN

New Patient Paperwork – Medical Weight Loss

After paperwork complete, and before consult, please email completed copy to thetrimtexan@gmail.com; or you may hand carry completed copy at time you come in for your free consultation.

Tell me about yourself!

Name:	Preferred Name:	Date:
Home Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email Address:		
Sex: M F NB	Birthday:	Ht/Wt:
Race:		
Marital Status: Single Married Widowed Separated Divorced		
Occupation:		
How did you hear about us?		
Primary Care Physician (if don't have one no problem!): Phone Number:		
Emergency Contact:	Phone:	Relationship:

Wellness History:

Have you been told by another doctor you need to lose weight:
Any dietary restrictions? If so, please list:
How frequently do you exercise? Type Exercise?
Have you sought medical weight loss before in past? If so, what medical weight loss options have been tried?
Are you…: pregnant? Might be pregnant? Breast feeding? On oral birth control? Actively receiving chemotherapy? Any history of pancreatitis? Are you a Type 1 Diabetic? Any personal or family history of medullary thyroid carcinoma (MCT)? Any personal or family history of multiple endocrine neoplasia syndrome type 2? Any cardiovascular history or history of a cardiovascular event?

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Please answer the below questions open and honestly so I can do my best to help **YOU** reach **YOUR** goals of becoming a Trim Texan!

What changed that you can think of that caused the weight gain (if can think of anything specific)?

What's the PRIMARY reason you are seeking medical weight loss at this time?

What are your goals about weight loss + control and long-term management?

What do you consider to be your ideal weight?

When was the last time you were at your ideal weight?

How much weight is your goal to lose?

How many times a year do you diet?

What do you feel is the hardest part about managing your weight?

What all besides what have listed above have you tried in the past that has failed?

Do you binge eat? □ Yes □ No
Do you suffer from uncontrollable cravings? □ Yes □ No
Do you feel that food controls you? □ Yes □ No
Do you eat because of your emotions? □ Yes □ No
Do you eat between meals? □ Yes □ No
What do you choose to eat between meals?
Do you feel that your eating behaviors are normal? □ Yes □ No
Briefly describe your daily eating behaviors:
Does your family support your weight loss efforts? □ Yes □ No
Can you remember being at your ideal weight? □ Yes □ No
What do you remember most about being at your ideal weight?
How determined would you say you are to lose weight?: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)

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Please list ALL medications + supplements you take (prescription & over the counter)

Drug Name: Dosage: How long have you taken & for what conditions?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list all known DRUG and FOOD allergies:

Drug Name/Food Name: Reaction:

_____ _____
_____ _____
_____ _____

Have you had lab work done within the last 12 months? _____

Please check ALL medical conditions that you may have had, OR currently have now:
__ADD/ADHD __Depression __Hepatitis __Miscarriage __Alcoholism
__Diabetes __High Blood Pressure __Multiple Sclerosis __Allergy __Eczema
__High Cholesterol __Parkinson's __Alzheimer's __Emphysema
__High Blood Sugar __Pneumonia __Anemia __Epilepsy/seizures __HIV/AIDS
__Raynaud's __Appendicitis __Fibromyalgia __Irritable Bowel
__Rheumatoid Arthritis __Asthma __Gall Bladder __Kidney Infect./stones
__Ringing in ears __Arthritis __Goiter __Low Blood Pressure __Sinus Infection
__Cancer __Gout __Low Blood Sugar __Stroke __Celiac Disease __Heart Attack
__Lyme Disease __Thyroid Problems __Chronic Fatigue __Heart Disease __Lupus
__Ulcers __Migraine __Vertigo/Dizziness
Other: _____

Please list all previous surgeries & dates:

_____
_____

Alcohol use? Yes / No
Amount _____ Daily / Weekly / Socially
Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

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AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined and treated by The Trim Texan medical team.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____