PASSER RESTORATIVE THERAPIES
10170 Nicholas St Omaha, Nebraska 68114
402-933-5958
MEDICAL WEIGHT LOSS

DO YOU HAVE A PACEMAKER? YES NO

Date: ______ Email address: ______________________________ Height: ______

Name: ____________________________ Age: _____ DOB: _______ Male/Female

Address: ____

Phone Home: ________________ Work: __________________ Cell: ___________

Employer: ______________________ Occupation: _________________________

Marital Status: ____ Emergency Contact: ________________ Phone: __________

Physicians Name: ___________________How did you hear about us? __________

LIST ALLERGIES TO MEDICATIONS, XRAY DYES, OR OTHER SUBSTANCES:

Drug Name	Reaction	Drug Name	Reaction
1. ____________________		4.____________________	
2. ____________________		5. ____________________	
3. ____________________		6. ____________________	
4.			

MEDICATIONS (PRESCRIPTIONS, OVER THE COUNTER, VITAMINS, HERBS)

NAME	NAME
1. ____________________	4.____________________
2. ____________________	5.____________________
3. ____________________	6. ____________________

MEDICAL HISTORY, TREATED OR UNTREATED:

Do you have a pacemaker or implanted cardiac defibrillator? Yes/No

Have you ever had heart surgery? Yes/No

Do you have a heart murmur, heart valve prolapse, heart palpitations? Yes/No

Have you ever had a heart attack or stroke? Yes/No

Do you have diabetes? Yes/No Insulin use? Yes/No

Do you have thyroid disease? Yes/No

Do you have high blood pressure? Yes/No

Have you ever had a blood clot? Yes/No

Have you ever been treated for cancer? Yes/No If yes, type: ______________________

Do you have kidney or liver problems? Yes/No

Have you been treated for a drug or alcohol addiction? Yes/No

Do you have epilepsy or a seizure disorder? Yes/No

Have you been treated for depression or anxiety? Yes/No

Do you smoke? Yes/No Type: ________________ Amount:__________

Do you have migraine headaches? Yes/No

Do you have frequent headaches? Yes/No

Do you have glaucoma? Yes/No

Do you have trouble swallowing? Yes/No

Do you have difficulty breathing? Yes/No

Do you have frequent chest pains? Yes/No

Do you have frequent diarrhea? Yes/No

Are you frequently constipated? Yes/No

Do you have trouble urinating? Yes/No

Do you have frequent back pain? Yes/No

Please elaborate on any of the above answers:

Are you pregnant? Yes/No

What birth control method are you using:________________________

First day of last menstrual cycle:________________________

Has any member of your family (including parents and siblings) ever had any of the following?

Illness	Which family member	Age diagnosed
Cancer	________________	____________
Hypertension (high blood pressure)	________________	____________
Heart Disease	________________	____________
Diabetes	________________	____________
Stroke	________________	____________
Mental Illness (anxiety, depression)	________________	____________
Drug or alcohol addiction	________________	____________
Glaucoma	________________	____________
Bleeding Disease	________________	____________
Other	________________	____________

HOSPITALIZATIONS/MEDICAL AND SURGICAL

Date

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

What is your main reason for wanting to lose weight?

____

Signature: ______________________________ Date: ________________

Clinician Notes:

____

____

____