PURE
HEALTH + IMAGE + LIFESTYLE CENTER

AgelessBeauty
Medical Spa & Weight Loss Center

Weight Management Consultation Questionnaire

Name:_____ DOB:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Daytime Phone Number:_____Email:_____

How did you hear about us?_____

Which weight loss program are you more interested in? (hCG, Phentermine, Medical Grade Supplements, I-Lipo Xcell)_____

To the best of your knowledge are you in good health presently? Yes_____No_____ (if no please explain_____

When did your weight gain begin? Month:_____Year:_____

What is your ideal weight goal?_____What is your current weight?_____

What weight loss treatments, products or programs have you tried before? And were you successful with any of them?

_____

_____

Have you had any bariatric surgeries performed? (gastric bypass, lap band) No_____ Yes_____ if yes what year and what surgery was performed?_____

Do you currently exercise? No_____ Yes_____ (if yes please describe your activity AND how often you perform this)_____

_____

Current Occupation:_____Full Time_____ Part Time_____

Please list all medications being taken including over the counter and any vitamins:

_____

_____

Any allergies to medications? Yes_____ No_____ if yes please list:_____

_____

Any history of high blood pressure? No_____ Yes_____

Are you pregnant or breastfeeding? No_____ Yes_____

Any history of kidney or liver function problems? No_____ Yes_____(if yes please explain)_____

Any history of drug or alcohol abuse? No_____ Yes_____(if yes please explain)_____

Any history of eating disorders? No_____ Yes_____(if yes please explain)_____

Any history of migraines or frequent headaches? No_____ Yes_____(if yes please explain)_____

Is your spouse/partner overweight? No_____ Yes_____ Is your spouse/partner supportive of your decision to seek out weight management aid? Yes_____ No_____ (if no please explain why)_____

_____

I have filled out this questionnaire truthfully and to the best of my knowledge.

Signature:_____Date:_____