Client History information Must be completed and reviewed prior to services.. Information must be completed by the client.

Although your diet program at De La Belle will be reviewed and monitored by our nursing staff and overseen by our Medical Director, it is strongly recommended that you consult your primary care physician prior to beginning any type of weight loss program.

Last Name ____________ First Name ____________ Middle Initial ______

Address:

Street, City, State ____________ Zip Code ______

Age ______ Date of Birth ___/___/___ Male / Female ( ) - Mobile Phone No. ( ) - Home Phone No.

Primary Care Physician ____________ Office Phone Number ____________

Emergency Contact and Relationship to ____________ Phone Number ____________

List ALL KNOWN OR ASSUMED Medication Allergies:

Do you have any known allergies to Sulfa Medications or Sulphur? Sulfa containing medications could include but are not limited to: Bactrim, Septra, Sulfonamides, Trimethoprim-Sulfa or SMZ-TMP, Silvadene Cream, Dapsone, or Erythromycin

List all vitamins, supplements, herbal medications, or over the counter medications you are currently taking:

Please list all current prescribed medications that you are taking including birth control medications:

I have answered the above questions to the best of my knowledge and understand that I should consult with my Primary Care Physician prior to beginning any type of weight loss program.

______________________________ Client Signature

______________ Date

______________________________ Client Printed Name

- -

Nursing staff to complete the remaining portions of this form

Weight	BMI	Fat Mass lbs.	Fat %	TBW	Pulse	Resp.	B/P
______	______	______	______	______	______	______	______

______ Client History Information completed, reviewed, and signed by client

______ Informed Consent reviewed and signed

______ Weight Loss Readiness Quiz Taken

______ Diet Program and Booklet Reviewed

______ Client Voices Understanding of Diet, participation requirements and discipline

______ Client demonstrates accuracy at preparing HCG syringe and giving injection

Client is a candidate for this diet program? Yes No

____

____

____

______________________________ Nurse Signature

______________ Date

______________________________ Medical Director Signature

______________ Date

			Not including today, Number of times you have been on the HCG Diet: _______, Maximum pounds lost on HCG Diet _______ or N/A
Approximate Height	Estimated Weight	Desired Weight	

If applicable, Date of Last Menstrual Period: ____________

Medical History Present Health Status

Are you currently under the care of a physician? No Yes

Have you had surgery in the last 4 weeks? No Yes

Recent Surgeries:

If yes, list name of physician and reason for treatment.

In YOUR opinion, not including your weight, do you consider yourself in "good physical health"? No Yes

Current or Past Medical History, Please check all that apply or circle N/A

☐ Diabetes	☐ Thyroid Disorder	☐ Other Endocrine Disorders	☐ High Blood Pressure
☐ Liver Disease	☐ Kidney Disease	☐ Leber's Disease	☐ Glaucoma
☐ Bleeding Disorder	☐ Anemias	☐ Heart Valve Disorder	☐ Heart Disease
☐ Rheumatic Fever	☐ Tuberculosis	☐ Lung Disease	☐ Ovarian Cysts
☐ Epilepsy or Seizures	☐ Cancers	☐ Abnormal Mammogram	☐ Blood Clots
☐ Digestive Disorder	☐ Auto-immune Disorder	☐ Pregnant or Lactating	☐ HIV-Aids
☐ Hepatitis	☐ Depression	☐ Mental Illness	☐ Gastroplasty
☐ Other:			

Approximate date of recent Blood work if Abnormal: ____________ ____________

Abnormal Findings or N/A

Activity Level (Choose Only One)

_______ Inactive: No regular physical activity with a basically sit-down job.

_______ Light Activity: No organized physical activity during leisure time.

_______ Moderate: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, cycling, etc.

_______ Heavy: Consistent weight lifting, aerobic exercise 3 or more times a week, regular participation in scheduled exercise activity, i.e. running, exercise class 3 times weekly, daily fast-paced walking.

_______ Vigorous: Exercise instructor or personal trainer, extensive physical exercise 60 min daily 5 times week, marathon or triathlon training, cycling 20 or more miles daily 4 or more times week.

Client Name: