de la Belle
WELLNESS & SPA
Aesthetics . Weight Loss . Laser

Patient Basic Information Form
Form must be completed before service
(to be filled out by patient)

CONSULT YOUR PHYSICIAN BEFORE STARTING ANY WEIGHT LOSS PROGRAM!

Your Name: Last _____ First _____
Name you prefer to be called: _____
Your Address: Street _____ Apt/Suite # _____
City:_____ State: _____ Zip Code: _____
Home Phone (Including Area Code): _____
Cell: _____
Birth date: _____ Current Age: _____ Sex: M F
Your e-mail address: _____
Emergency Contacts
(at least 2 other people)
Name: _____ Relationship _____ Phone _____
Name: _____ Relationship _____ Phone _____
Primary Care Physician: _____
Phone _____

Referred by: _____
How did you hear about us? (please check all that apply)
___Radio ___Mail-out ___Internet ___Saw a Sign

___Television ___Newspaper ___Word of Mouth

Present Health Status:

1. Are you in good health at the present time, to the best of your knowledge? Yes/ No
Explain a "no" answer:_____
_____

2. Are you under a doctor's care at the present time? Yes/ No
If "yes," for what?.
3. Are you taking any medications at the present time? Yes/ No
Prescription Drugs (List all with
dosage)_____
_____
_____

Over the Counter medication, vitamins, supplements, etc. (List all with
dosage)_____
_____
4. Any allergies to any medications INCLUDING SULFA Yes/ No
Please List:

5. History of Diabetes? Yes/ No
At what age: _____
6. History of Heart Attack or Chest Pain or other Heart condition?
Yes/ NO
7. History of Swelling Feet? Yes/ No
8. History of Frequent Headaches? Yes /No
Migraines Yes/ No Medications for Headaches: _____
11. History of High Blood Pressure? Yes/No
12. History of Glaucoma? Yes /No
13. History of Sleep Apnea? Yes/ No
14. Any Surgery? Yes/ No
Specify with date: (List all, use back of page if ne

Past Medical History (check all that apply)

_____ Gallbladder Disorder _____ Jaundice _____ Kidneys ___Tonsillitis
_____ Nervous Breakdown _____ Pleurisy _____ Scarlet Fever ___Ulcers
_____ Rheumatic Fever _____ Tuberculosis _____ Drug Abuse ___ Anemia
_____ Blood Transfusion _____ Pneumonia _____ Arthritis ___Gout
_____ Whooping Cough _____ Eating Disorder _____ Typhoid Fever ___Chicken Pox
_____ Bleeding Disorder _____ Osteoporosis _____ Liver Disease ___Lung Disease
_____ Heart Valve Disorder _____ Thyroid Disease _____ Heart Disease ___Alcohol
Abuse____ Psychiatric Illness ____ Cancer _____ Measles ___Other_____
Date of last blood/lab work/ EKG_____
Please list any abnormalities_____
_____

Family History:

Tell us of your family's medical history to the best of your ability including these items as they apply: Age | General Health | Diseases Overweight | Cause of Death

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Has any blood relative ever had any of the following?

High Blood Pressure: Yes/ No Who: _____

Kidney Disease: Yes/ No Who: _____

Heart Disease/Stroke: Yes/ No Who: _____

Nutritional Evaluation

1. What is the main reason for your decision to lose weight?

_____

_____

2. Desired weight:_____
3. In how many months would you like to be at this weight? _____
4. Weight one year ago? _____
5. When did you begin gaining excess weight? (give reasons, if known)

_____

_____

6. What is the most you have weighed (non-pregnant) and when?

_____

7. How often per week do you eat out? _____
8. How often per week do you eat "fast food?" _____
9. Foods you are allergic to:

_____

10. Foods you strongly dislike:

_____

11. Foods you crave: _____
12. Times of day or month that you crave food? _____
13. Do you drink coffee or tea? Yes? No How much daily? _____
14. Do you wake up hungry in during the night? Yes/ No How often? _____
16. Previous diets you have followed: list description (or name) and your results

_____

_____

_____

_____

_____

_____

Lifestyle Considerations

This information will assist us in assessing your particular problem areas as it relates to weight and health, and establishing your medical management. Thank you for your time and patience
in completing this form.

1. Do you drink alcohol? Yes/ No
Daily Yes /No Weekly Yes/ No Occasionally Yes/ No

2. Smoking Habits (choose only one)
_____ You have never smoked cigarettes, cigars or a pipe
_____ You have quit smoking _____ years ago and have not smoked since_____
_____ You smoke 20 cigarettes per day (1 pack)
_____ You smoke 30 cigarettes per day (1 ½ packs)
_____ You smoke 40 cigarettes per day (2 packs) or more

3. Activity Level (choose only one)
_____ Inactive: no regular physical activity with a sit-down job.
_____ Light activity: no organized physical activity during leisure time.
_____ Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____ Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session for times per week.

Are you taking other medications or herbal preparations?
Prescribed: Yes/ No Over-the-counter: Yes /No
If yes, please list carefully and review with the staff person or nurse:
_____
_____
_____

SIGNATURE _____ DATE_____

MEDICAL PERSONNEL_____ DATE_____