EMPOWER
WEIGHT LOSS ASSOCIATES
MEDICAL WEIGHT LOSS SOLUTION

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## 1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Occupation: _____

Marital Status:
○ Married ○ Divorced ○ Widow
○ Living with Partner ○ Singe

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

May we contact you via E-mail?
○ Yes ○ No

In case of Emergency Contact: _____

Emergency Contact Phone Number: _____

Primary Care Physician's Name and phone number: _____

Primary Physician Address: _____

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name or Significant Other _____

Relationship _____

Home Phone Number: _____

Cell Phone: _____

Work Phone: _____

## 2. Social:

☐ I am sexually active.
☐ I have completed my family
☐ My sex has suffered.
☐ I haven't been able to have an orgasm.
☐ I want to be sexually active.

3. **Habits:**

| | How much? | How often? |
|---|---|---|
| Smoking- cigarettes/cigar | | |
| Alcohol | | |
| Recreational drugs | | |
| Tea | | |
| Coffee | | |

4. **Any known drug allergies:**

_____

5. **Have you ever had any issues with anesthesia?**

- ○ Yes
- ○ No

**If yes, please explain**

_____

6. **Please list any prescribed medications you take:**

| | Name | Dosage |
|---|---|---|
| 1 | | |
| 2 | | |

7. **Current Hormone Replacement Therapy:**

_____

8. **Past Hormone Replacement Therapy:**

_____

9. **Please list any nutritional/vitamin supplements you currently take:**

| | Name of supplement | Dosage |
|---|---|---|
| 1 | | |
| 2 | | |

10. **Surgeries, list all and when:**

_____

_____

_____

_____

11. **Last menstrual period (estimate year if unknown):**

_____

12. Other pertinent information:

13. Preventive Medical Care:

- ☐ Medical/GYN exam in last year
- ☐ Mammogram in the last 12 months
- ☐ Bone Density in the last 12 months.
- ☐ Pelvic Ultrasound in the last 12 months.

Please explain if needed:

14. High Risk Past Medical/Surgical History:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only.
- ☐ Oophorectomy-removal of ovaries.

Explain please:

15. Birth Control Method:

- ○ Menopause
- ○ Tubal Ligation
- ○ Vasectomy
- ○ Hysterecotomy
- ○ Birth Control Pill
- ○ Other

Please explain "other"

16. Medical Illnesses: Please tick the boxes which indicate conditions you have had or presently have. If any other conditions, please list them on the box down below:

- ☐ Arrhythmia
- ☐ AIDS/HIV
- ☐ Angina
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Blood clot
- ☐ Heart Disease
- ☐ Hepatitis A, B or C
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Heart Bypass
- ☐ Fibromyalgia
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Auto Immune Disease
- ☐ Liver Disease (hepatitis, fatty liver, cirrhosis)
- ☐ Mood disorder
- ☐ Polycystic Ovary Syndrome(PCOS)
- ☐ Pulmonary Emboli
- ☐ Psychiatric Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Other(s)
- ☐ No medical problems

If cancer: Type and Year

_____

17. Family History: Please tick any family history listed below:

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Alzheimer's Disease
- ☐ Breast Cancer
- ☐ No family history

Please explain:

_____

18. How did you hear about our clinic?

- ☐ Internet Search
- ☐ Yelp
- ☐ Family/Friend
- ☐ BioTE website
- ☐ Facebook
- ☐ Other

19. Please Answer Below:

| Symptom (please check mark) | Never | Mild | Moderate | Severe |
|---|---|---|---|---|
| Depressive Mood | | | | |
| Memory Loss | | | | |
| Mental Confusion | | | | |
| Decreased Sex Drive/Libido | | | | |
| Sleep Problems | | | | |
| Mood Changes/Irritability | | | | |
| Tension | | | | |
| Migraine/severe headache | | | | |
| Difficult to Climax Sexually | | | | |
| Bloating | | | | |
| Weight Gain | | | | |
| Breast Tenderness | | | | |
| Vaginal Dryness | | | | |
| Hot Flashes | | | | |
| Night Sweats | | | | |
| Dry and Wrinkled Skin | | | | |
| Hair Falling Out | | | | |
| Cold all of the time | | | | |
| Swelling all over the body | | | | |
| Joint Pain | | | | |