Name:_____ Age:_____ Date:_____ MR#_____

Welcome to the Harmony Weight Control Plan at Harmony Medical Spa. Please answer all questions as honestly and completely as possible to help us understand you better.

When did your weight problem begin? _____
Was the weight gain rapid or slow? _____
What have you tried in the past to lose weight? _____
Have you ever used diet pills, either prescription or over the counter? _____
Have you ever been diagnosed with an eating disorder? _____
How much sleep do you get? _____
Do you frequently feel tired or lack energy? _____
How much water do you drink daily? _____
Do you eat breakfast? _____
How many times a day do you sit down at a table to eat a meal?_____
Do you eat late at night? _____
Do you eat in front of the TV or computer? _____
Are there triggers that cause you to overeat? _____
Are there any foods you just can't live without? _____
How much alcohol do you drink?_____
How frequently do you exercise? _____
What type of exercise do you do _____
If you don't exercise, why? _____
Do you have any medical problems? (please circle): High blood pressure, Diabetes, Stroke Heart Disease, High Cholesterol, Thyroid disease, Sleep disorder, Migraine headache, Kidney problems, Hepatitis, Cancer, Other _____
Have you ever had weight loss surgery? _____
List any other surgeries you have had? _____
Is anyone in your family obese? _____
Marital status (please circle): Single, Co-habitating, Married, Divorced, Widowed
Do you smoke (please circle): Never, In the past, Yes ____ packs per day
What is your occupation? _____
Why do you want to lose weight? _____
Whom may we thank for referring you to our program? _____

Please do not write below this line

ALLERGIES: _____
VITAMINS/ HERBS: _____
_____
_____
MEDICATIONS:_____
_____
_____
_____
_____
_____
_____

ROS ____ Not Performed
____ Performed. Significant findings:
_____
_____

____ I have reviewed this information with the patient.

_____
Physician Signature