Southwest Missouri Wellness Center

21088 US-71 Suite 7, Jane, Missouri 64856

office: (417) 226-1300
fax: (417) 226-1302

Patient Name:_____ Cell #:_____

Address:_____ Text Remind OK: ◯ Yes ◉ No

City:_____ State:_____ ZIP:_____ Alt Phone #:_____

Current Age:____ DOB:_____ SSN:_____

Have you ever taken Phentermine before? If so, what dosage?

_____

Who referred you to our clinic? _____

How did you learn about us?

☐ Facebook ☐ Website ☐ Google ☐ Online Ad ☐ Other

Weight History:

1. When did you first notice you might be overweight? Age:_____
2. What is your goal weight?_____ Height:_____
3. Have you tried other diets? If so, please list types of plans below:

   _____
   _____
   _____

4. Do you exercise regularly? ◯ Yes ◯ No If Yes, please describe below:

   _____
   _____
   _____

5. Below list all foods and beverages you like to consume on a regular basis.
   Example: Lunch—Cheeseburger, fries, Coke, bowl of chili, burrito, two slices of pizza.
   a. Breakfast:_____
   b. Lunch:_____
   c. Dinner:_____

6. From question #5, pick a typical meal from each category.
   Example: Lunch—Cheeseburger, fries and coke.
   a. Breakfast:_____
   b. Lunch:_____
   c. Dinner:_____

7. What time of day do you usually snack?_____

Patient Name: _____

1. List all past and current medical problems:

_____
_____
_____

2. List all previous surgical procedures:

_____
_____
_____

3. List all current medications:

_____
_____
_____

4. List all allergies to medications:

_____
_____
_____

5. List all known medical problems within your immediate family:

_____
_____
_____

6. Do you consume alcoholic beverages? ◯ Yes ◯ No

7. Do you use tobacco? ◯ Yes ◯ No

8. Have you ever suffered from (check all that apply):

◯ Depression	◯ Diabetes	◯ Gallstones
◯ Enlarged thyroid	◯ Heart Disease	◯ High blood pressure
◯ Liver disease	◯ Headaches	◯ Stroke

9. Are you pregnant/nursing? ◯ Yes ◯ No Last Menstruation Date (Approx):

10. Occupation: _____

11. Regular family physician:

Name: _____
City: _____
Phone: _____