Divine Weight Management Program
New Patient Information

Last Name: ________________ First Name: ________________ MI: ____________

Date of Birth: ________________ Age: ______________ Marital Status: __________

Gender: ☐Male ☐Female

Address: ____

City: __________________________ State: __________________ Zip Code: ________

Mobile Number: _________________________ Home Number: _________________

Email Address: ____

Employment Information:

Employer: ______________________ Occupation: ______________________________

Work Number: _____________________________

Emergency Contact:

Name: _____________________________ Relationship: ________________________

Cell Number: ________________________ Work/Home Number: ______________

Preferred Method of Contact:

With my permission, this establishment, may contact me and leave voicemail messages in reference to any subject that assists in carrying out patient relations, such as, but not limited to: appointment reminders and laboratory results.

My preferred method of contact: _____Mobile ____Home _____Work ______Email

How did you hear about this office? ____

____

What diet program have you tried in the past? ________________________________

Current medications:

Medication allergies:

Please list any surgeries with date:

Please list any recent or current medical conditions that we should be aware of:

Do you have a personal or family history of any of the following conditions?

Heart disease: ☐ Yes ☐ No Blood Disorders: ☐ Yes No ☐ Depression: ☐ Yes ☐No

Kidney Disease: ☐ Yes ☐ No Lung Disease: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No

Hypertension: ☐ Yes ☐ No Seizures:☐ Yes ☐ No

Cystic Fibrosis:_☐ Yes ☐ No

Sexually Transmitted Diseases: ☐ Yes ☐ No Nervous Diseases: ☐ Yes ☐ No

Psychiatric Disorders: ☐Yes ☐No

Are you pregnant?: ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No

Have you been diagnosed with an autoimmune disorder?☐ Yes ☐ No

Do you take aspirin on a regular basis or take blood thinners?☐ Yes ☐No