MERIDIAN AESTHETICS AND WELLNESS
Carlo E. Gopez, M.D.   Helene Lee, M.D.
115 North Bridge Street, Elkton, MD 21921
(Tel) 410-398-3041   (Fax) 410-392-6853

Medical Weight Loss New Patient Intake Form
Welcome To Our Weight Loss Clinic!

Name: ______________________________ Date of Birth: _____________
Today's Date: ____
Address: ____
City / State / Zip: ____
Home Phone: ___________________ Cell Phone: ___________________
Email Address: ____
Birth Date: _________________ Marital Status S M D W
How Did you hear about our office: ______________________________

Are you under a doctor's medical supervision at this time? Yes No
If Yes, medical providers name?
____

Are you taking any medications at the present time? Yes No
If Yes, what medications? ____
____

Do you take vitamin supplements? Yes No
If Yes, what do you take? ____
____

Medical history:
History of high blood pressure? Yes No
History of diabetes? Yes No
Do you snore or have sleep apnea? Yes No
Personal history of Pancreatitis? Yes No
Personal history of Medullary Thyroid Cancer? Yes No

Other significant current medical
problems:____
____
____

Family history of Medullary Thyroid Cancer or Multiple Endocrine
Neoplasia type 2 (MEN2) Syndrome? Yes No

Any Allergies to medications? ______________________________________
____

Nutritional Evaluation:
Present Weight: __________ Height: ___________ Desired Weight:__________
When would you like to be at your desired weight?______________________
Why do you want to lose weight? (Health Benefit? Appearance, etc.?) Please
explain:
____
____

What has been your maximum weight (non-pregnant)? ____________________
Have you tried other weight loss programs? Yes No
If yes, which ones? ____
Is your spouse, fiancee or partner overweight? Yes No N/A
How often do you eat out? _______________________________________
Food allergies? ____
Do you drink coffee or tea? Yes No If Yes, how much daily? __________________
Do you drink pop / soft drinks? Yes No If Yes, how much daily? _______________
What are your worst food habits? ____________________________________
____
Snack habits: What: ____
How Much: ____
When: ____
Do you eat because of emotions ? ___________________________________
Amount of stress in your life on a scale of 1-10? __________________________
When there is increased stress in your life, do you tend to eat more? Yes No

Typical Breakfast: ____

Typical Lunch: ____

Typical Dinner: ____

Factors you feel have contributed to your current weight
(circle all that apply): Weight gain following an injury / Pregnancy/ Poor food choices / Stress-related eating / Slow metabolism / Family history of obesity/ Comfort food dependency / Lack of exercise / Binge eating / Late night snacking / History of grief or loss / Medication-related weight gain/ Significant restrictive eating behaviors (ex. anorexia)

Have you tried any of these weight loss therapies in the past?
(circle all that apply):
Medications: Meridia, Alli, Phentermine, Adipex, Dexatrim, Metabolife, Acutrim, Qsymia, Belviq, Contrave, Saxenda, Prozac, Metformin
Other medications:
____
Nutritional supplements such as B12 Shots, HCG Shots or Diuretics
Weight Watchers Meal Replacement Programs Registered Dietitian
Counseling or other Counseling or Therapy
Acupuncture or Hypnosis
Other methods::
____

Do you exercise: Yes No
If yes, what kind of exercise?____
How often do you exercise?____
Describe your energy level? Low Average High
Activity Level: (check one) ________ Inactive ________ Light Activity __________
Moderate Activity ________ Heavy Activity ________Vigorous Activity
How many hours on average of sleep do you get per night:_________________

On a scale of 1 to 10 with 10 being MOST committed, how committed are you to taking action and making a change in your life today?__________________

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