Maui Medical Weight Loss Clinics, LLC

Patient Registration Form

Name_____Home Phone_____

Cell _____

Work_____

DOB_____Age_____Sex_____Marital Status__Yes_____No_____

Address_____

Occupation_____***EMAIL _____

Primary Care Physician_____Phone _____

Address_____

Allergies_____

Emergency Contact_____Home_____

Cell_____

Medications_____

_____

_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment on date of service. I understand that Maui Medical Weight Loss Clinics doesn't take health insurance or bill the patient health insurance company.

Form of payments may be made by cash preferred. No charge cards accepted. Check are only accepted after patient is established and approved by the medical staff.

PATIENT SIGNATURE_____**DATE**_____

Maui Medical Weight Loss Clinics Patient Confidential History

Name_____SEX_____DOB_____Age_____Date-____

Primary Physician_____phone_____

Weight_____Height_____Goal

Date of Last EKG_____Last Bloodwork_____Last Physical_____

Last GYN visit_____

Allergies _____

Current Medications	**Dose**	**Frequency**	**Reason**
1.			
2.			
3.			
4.			
5.			
6.			

Hospitalizations/ Surgeries

	Year	**Diagnosis**	**Hospital**
1.			
2.			
3.			

Prevention : Please put date received next to test

Women: Pap_____Mammography_____Self Breast Exam_____Flu vaccine_____PNA vaccine_____

Men: PSA_____ Prostate Exam_____ Flu vaccine_____ PNA vaccine____Eye Exam_____

Healthy History Cont: Please check if YES

	Patient	Family
Anemia	_____	_____
Alcohol Abuse	_____	_____
Angina/ Chest pain	_____	_____
Anxiety	_____	_____

Maui Medical Weight Loss Clinics Patient Confidential History Cont.

	Patient	**Family**
Arthritis	_____	_____
Asthma	_____	_____
Atrial Fibulation	_____	_____
Back pain/ Injuries	_____	_____
Bleeding disorder	_____	_____
Cancer	_____	_____
Constipation/ Diarrhea	_____	_____
CVA/ Stroke	_____	_____
Depression	_____	_____
Diabetes Type 1 or 2	_____	_____
Difficulty urination /Odor	_____	_____
Eating Disorders	_____	_____
Glaucoma	_____	_____
Gouty Arthritis	_____	_____
Hair Loss	_____	_____
Head Aches / Migraines	_____	_____
Heart Disease	_____	_____
Heart Palpitations	_____	_____

Healthy History Cont:

	Patient	Family
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Incontinence Urine/ Stool	_____	_____
Insomnia	_____	_____
Kidney Disease	_____	_____
Leg Cramps	_____	_____
Loss of Balance	_____	_____
Liver Disease	_____	_____
Lung Disease	_____	_____
Memory Loss	_____	_____
Mental Illness	_____	_____
Reflux Disease	_____	_____
Seizures	_____	_____
Short of Breath	_____	_____
Sleeping Disorders	_____	_____
Hyperthyroid	_____	_____
Hypothyroid	_____	_____
Vertigo/ Dizzy	_____	_____

Tobacco:

1. Do you smoke cigarettes? ____ Yes ____ No
2. How many a day and for how many years?_____

Exercise

1. Do you exercise?_____
2. How often?

   _____

Alcohol and Drugs

1. Do you drink Alcohol?_____
2. If yes how often? _____
3. Do you presently use recreational drugs?_____

Sex

1. Are you sexually active?_____

Women

1. Date of last menstration_____
2. Are you pregnant, trying to conceive, or breast feeding?
   _____

Patient Questionnaire:

1. Are you on a weight loss diet now?_____
2. Did you lose or gain weight recently? _____
3. How much weight to you want lose weight? _____
4. How often do you dine out?_____
5. What is your favorite food?_____
6. Is your family over weight?_____
7. Do you eat late at night? _____
8. How often do you cook?_____
9. What do you normally eat for breakfast?_____
10. Lunch?_____
11. Dinner? _____
12. What snacks do you like ? _____

I agree that the information in my medical history is accurate.

Patient's signature_____Date_____