Baum Weight Loss Program

Patient Registration

Patient name (first & last): _____ Date of Birth: ___ / ___ / ___
Cell Phone # (____)_____-_____ Email:_____
Address_____
City:_____ State:_____ Zip_____
Ethnicity / Race: _____
Primary Language: English / Spanish / Other_____
Preferred method of communication: Cell Phone / Text / E-mail / Mail

Emergency Contact Info

Name: _____ Relationship to patient: _____
Emergency contact cell phone # (_____)_____-_____ Work # (_____)_____-_____
Address:_____
City: _____ State_____ Zip _____

Medication/Name	**Dose/Frequency**
_____	_____/_____
_____	_____/_____
_____	_____/_____

Medical History

Yes ___	No___	Diabetes
Yes___	No___	High Cholesterol/Hyperlipidemia
Yes___	No___	Hyperthyroidism
Yes___	No___	Obstructive sleep apnea
Yes___	No___	Congestive Heart failure/CHF
Yes___	No___	Anemia
Yes___	No___	High Blood pressure/Hypertension
Yes___	No___	Hypothyroidism
Yes___	No___	Depression/Anxiety
Yes___	No___	Family history of heart disease?
Yes___	No___	Do you have: palpitations, heart murmur, or irregular heartbeat
Yes___	No___	Have you ever used phentermine?

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Surgical History

Yes___	No___	Pacemaker/Defibrillator
Yes___	No___	Gallbladder removed/Cholecystectomy
Yes___	No___	Gastric Sleeve
Yes___	No___	Abdominal surgery
Yes___	No___	Gastric Bypass
Yes___	No___	Thyroid Surgery

Social History

Yes___	No___	Are you a smoker? Former smoker?
Yes___	No___	Do you use marijuana?
Yes___	No___	Do you use any recreational drugs? Ex:(Meth, Cocaine, Ecstasy, heroin, PCP)

Any allergies to medication(s)? If yes

MEDICATION	**REACTION**
_____	_____
_____	_____
_____	_____