Botox & Laser Center

HCG WEIGHT LOSS PROGRAM FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ______/_____/_____ DATE OF LAST PHYSICAL EXAM _____/_____/_____
LAST NAME ________________________ FIRST NAME: ___________________AGE______
SOCIAL SECURITY NO. ____________________ DATE OF BIRTH: ______/_______/_______

When did you first become overweight? (Your age then) __________ (year) ___________
How did your weight gain start? Describe any circumstances:
____
What do you think is the cause of your weight problem?
____

Your present weight: ___________ your weight goal: ____________ height: ___________

What was your highest weight? (Excluding pregnancy) ______; your age then _______;
# of years ago _____. What was your lowest weight? ______; your age then _______;
# of years ago _____.

Have you ever stayed the same weight for 10 years or more? Yes/ No
Have you attempted to lose weight before? _____; most lbs lost: ____; how long it look: _____.
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, etc) and describe your results:
____
____
____

Where and when do you do most of your overeating?
____
____

Please make any comments that you think might be helpful:
____
____

Do you currently have any medical concerns? Please List:
____
____