a practice by JOHN P. SCHILLING, MD
schilling
COSMETIC SURGERY & AESTHETICS

Medical WEIGHT-LOSS Data Form

(If you become an obstetrical, gynecologic or cosmetic surgery patient - you MUST fill out complete history form - this form is for weight-loss only.)

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SchillingMedicalSpa.com

Patient ID: ←(FOR OFFICE USE) **Today's Date:**

Patient Name: _____ DOB: _____ Social Security #: _____

Address: _____

_____

EMERGENCY CONTACT Name: _____

Mailing Address (if different): _____ EMERGENCY CONTACT Phone: _____

_____ Relationship: _____

☐ Home: _____

☐ Cell: _____ CHECK PREFERRED ←CONTACT NUMBER

☐ Work: _____ Employer: _____

Email Address: _____ Occupation: _____

How did you hear about us? _____ If a friend, name? _____

Please tell us what you would like more information about:

☐ Facials - Facial Services	☐ Rosacea	☐ Laser Skin Tightening/Anti-Aging	☐ Facial Fat Grafting
☐ Chemical Peels	☐ Microdermabrasion	☐ Laser Hair Reduction	☐ Buttocks Enhancement
☐ Home Skin Care Products	☐ Neurotoxins (e.g. Botox/Xeomin)	☐ Laser Vein Treatment	☐ Breast Augmentation
☐ Hyper-Pigmentation	☐ Fillers (e.g. Juvéderm, Sculptra...)	☐ Liposuction	☐ Kybella
☐ PDO Threads	☐ Laser Stretchmark Reduction	☐ Lipo-Abdominoplasty (Tummy Tuck)	

Please check all that apply:

☐ Breast-feeding	☐ Blood Pressure	☐ Depression	☐ Fibromyalgia	☐ Numbness	☐ Varicose Veins
☐ Arthritis	☐ Cancer	☐ Edema	☐ Heart Disease	☐ Sinus Problems	☐ Clotting Disorders
☐ Anemia	☐ Chronic Pain	☐ Epilepsy	☐ HIV / Aids	☐ Smoker	
☐ Asthma	☐ Diabetes	☐ Fatigue	☐ Insomnia	☐ Spinal Problems	

MEDICAL HISTORY

	NO	YES	
Has your current weight remained stable over the last 5 years?	☐	☐	If NO, how much has it fluctuated? _____
How many diets have you tried over the last 5 years?	☐	☐	If yes, how many pounds did you lose? _____
Have you previously taken over-the-counter or prescription weight loss drugs?	☐	☐	If yes, specify: _____
How many hours a week do you exercise? _____			
Do you drink alcohol?	☐	☐	If yes, how much? _____
Are you taking anti-depressant or anxiety medication?	☐	☐	If yes, specify: _____
List any medications you are presently taking: _____			
Do you have any drug allergies?	☐	☐	If yes, specify: _____
Have you or anyone in your family been diagnosed with thyroid problems?	☐	☐	If yes, specify: _____
Have you ever been diagnosed with Metabolic Syndrome?	☐	☐	If yes, specify: _____
Have you been diagnosed with poly-cystic ovarian syndrome (PCOS)?	☐	☐	If yes, specify: _____
Are you currently pregnant / thinking in near future/ or breast-feeding?	☐	☐	If yes, specify: _____
If, applicable, when was your last menstrual period?			LMP: _____

DESIRED GOAL WEIGHT: _____

OFFICE USE ONLY:

CURRENT WEIGHT: HEIGHT:

ABDOMINAL GIRTH: BMI:

CONSENT AND SIGNATURE

I have listed all known medical/physical conditions, if there are any changes in the future, I will inform my PROVIDER at Schilling Cosmetic Surgery & Aesthetics of any changes. I agree to pay for all services at time they are rendered.

I understand that when scheduling an appointment I am required to reserve the appointment with a Credit Card or Gift Card number and a 24 hour notice is required to avoid paying missed appointment fees. A $30 fee will be charged for all returned checks.

I acknowledge by my signature below that I have read and understand the above statements and give my permission to receive this and any further treatments at Schilling Cosmetic Surgery & Aesthetics. I confirm to the best of my knowledge that the answers I have given on both pages, are correct and, that I have not withheld any information that may be relevant to my treatment.

_____ _____

Signature Date today (please add additional date if information is updated)

Clear Form

Complete - Print