

ROBERT SKVERSKY, M.D., INC. – WEIGHT NO MORE

320 SUPERIOR AVENUE - #210
NEWPORT BEACH, CA 92663
OFFICE: (949) 645-2930
FAX: (949) 645-1059

31537 RANCHO PUEBLO ROAD - #105
TEMECULA, CA 92592
OFFICE: (951) 699-0848
FAX: (951) 699-0509

PATIENT INFORMATION – PLEASE PRINT CLEARLY

DATE: _____

PATIENT'S NAME: _____ SOC. SEC.#: _____

STREET ADDRESS: _____ SEX (CIRCLE): M OR F

CITY: _____ DATE OF BIRTH: _____

STATE: _____ ZIP CODE: _____ AGE: _____

HOME PHONE: (_____) _____ MARITAL STATUS: _____

CELL PHONE: (_____) _____ EMAIL: _____

HEIGHT: _____ FRAME: _____ DRIVER'S LICENSE: _____

EMPLOYER INFORMATION – (PARENT INFORMATION IF PATIENT IS A MINOR)

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ WORK PHONE: _____

EMPLOYER CITY: _____ EXTENSION: _____

STATE: _____ ZIP CODE: _____

ADDITIONAL INFORMATION – PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ PHONE: (_____) _____

REFERRED BY: _____

MEDICATIONS YOU TAKE: (Name, how often, dosage)

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF TREATMENT. I UNDERSTAND THAT WEIGHT NO MORE DOES NOT BILL ANY INSURANCE COMPANIES AND THEREFORE, I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES.

PATIENT SIGNATURE

MEDICAL HISTORY

MEDICAL: HAVE YOU EVER BEEN TOLD THAT YOU HAD

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ANGINA | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> EMPHYSEMA |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> DIVERTICULITIS | <input type="checkbox"/> HYPERCHOLESTEROLEMIA | <input type="checkbox"/> OTHER _____ |
| | <input type="checkbox"/> ASTHMA | _____ |

HAVE YOU HAD AN ELECTROCARDIOGRAM DONE IN THE PAST YEAR? YES _____ NO _____

SURGERIES

AGE / YEAR PERFORMED

TONSILS AND ADENOIDS _____

APPENDECTOMY _____

OTHER: _____

HOSPITALIZATIONS:

OTHER THAN SURGERIES NOTED ABOVE

FAMILY HISTORY:

ALIVE / DECEASED

AGE IF DECEASED

CAUSE

FATHER _____

MOTHER _____

BROTHERS _____

SISTERS _____

CHILDREN _____

DO ANY ILLNESSES RUN IN THE FAMILY? IF YES, WHAT?

SOCIAL HISTORY:

DO YOU SMOKE? YES ___ NO ___ IF YES, FOR HOW MANY YEARS? _____
HOW MANY PACKS A DAY HAVE YOU AVERAGED OVER THOSE YEARS? _____

DO YOU DRINK ALCOHOL? YES ___ NO ___
DO YOU DRINK COFFEE? YES ___ NO ___ REGULAR ___ DECAF ___ CUPS/DAY _____
DO YOU EXERCISE? YES ___ NO ___ IF YES, TYPE AND FREQUENCY? _____

ARE YOU PREGNANT? YES ___ NO ___

DO YOU PLAN ON PREGNANCY IN THE NEXT 3 MONTHS: YES ___ NO ___