Versalo M.D. Weight Loss

Patient Information Form

Patient Name: **(**Last**)** _____ **(**First**)** _____ **(**MI**)** ____
Address: _____ City: _____
State: _____ Zip: _____ Phone: (_____) _____
Email: _____ Sex: Female or Male (Circle)
DOB: _____ Age: _____SSN:_____-_____-_____
Occupation: _____ Driver's License#:_____
Weight (If Known):_____ Ideal Weight: _____
When did you weigh your ideal weight? _____
How much weight do you want to lose? _____
Who else is overweight in your household? _____

Medical History

Are you currently taking any medication? Yes or No (Circle) if yes, please list all:

_____

Have you ever taken medication for weight loss? Yes or No (Circle) if yes, which one:

_____

Any Allergies? (***Please list ALL)***_____

Please circle any that apply
History of High Blood Pressure? Yes or No
History of Diabetes? Yes or No
History of Heart Attack or Chest Pain? Yes or No
History of Swelling of the Feet? Yes or No
History of Headaches/Migraines? Yes or No
History of Constipation? Yes or No
History of Glaucoma? Yes or No

Financial Policy

Please be advised that payment for all services will be due at the time services are rendered.

All the above personal information are true to the best of my knowledge, I understand and agree to the financial policy.

_____ _____

Patient Signature **Date**