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**