RICHMOND Weight Loss

Real people. Real results.

1-804-594-0085
Help.richmondweightloss@gmail.com

Patient Intake (page 1 of 2)

Patient Information

Date: _____

Name: _____

E-Mail :_____

Phone:_____ Cell:_____

Address: _____

_____,_____,_____

City State Zip

Sex: ❑M ❑F Age: _____DOB:____/_____/_____

SSN:_____

Occupation:_____

Employer:_____

How did you hear about us?

❑Doctor referral _____

❑Patient referral _____

❑Television channel_____

❑Internet website_____

❑Newspaper_____

❑Other_____

Goals:

How many inches do you want to lose?

_____

How many pounds do you want to lose?

_____

Desired Completion Date:_____

Treatment History

History of previous treatments, diets, other? ❑ Yes ❑No If yes, please specify and why it didn't work for you?_____

_____

_____

Social History

Exercise? ❑None ❑Moderate ❑Daily Habits? Smoking # packs_____ Day / Week

Alcohol # drinks_____ Day / Week Coffee/Caffeine # cups_____ Day

Past Surgical History

❑I DO NOT have a history of any previous surgeries.

Type of Surgery/Year/Surgeon?_____

Past Medical History

Anemia	❑Y ❑N	Cong Heart Failure	❑Y ❑N	Lung Problems	❑Y ❑N
Arthritis	❑Y ❑N	Coronary Artery Dis	❑Y ❑N	Multiple Sclerosis	❑Y ❑N
Asthma	❑Y ❑N	Diabetes	❑Y ❑N	Osteoporosis	❑Y ❑N
Atrial Fibrillation	❑Y ❑N	Emphysema	❑Y ❑N	Pacemaker	❑Y ❑N
Bladder Problems	❑Y ❑N	Epilepsy/Seizure	❑Y ❑N	Parkinson's	❑Y ❑N
Blood Clots-legs	❑Y ❑N	Gout	❑Y ❑N	Stroke CVA / TIA	❑Y ❑N
Blood Clots-lungs	❑Y ❑N	Heart Disease	❑Y ❑N	Thyroid	❑Y ❑N
Blood Press high/low	❑Y ❑N	Hernia	❑Y ❑N	Other _____	

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Patient Intake (page 2 of 2)

Current Conditions			
Pregnant Now, or trying	❑Y ❑N	Lupus Erythematosus	❑Y ❑N
Kidney Problems	❑Y ❑N	Active Cancer within a Year	❑Y ❑N
Doctor said you should avoid light?	❑Y ❑N	Autoimmune disease	❑Y ❑N
Liver Problems	❑Y ❑N	Albinisms	❑Y ❑N

Current Photo-Sensitive Medications					
Gold or Gold 50	❑Y ❑N	Hostacycline	❑Y ❑N	Chloropromazine	❑Y ❑N
Fulvicin P/G or Fulvicin U/F	❑Y ❑N	Lymercycline	❑Y ❑N	Grifulvin V or Griseofulvin F	❑Y ❑N
Gris-Peg	❑Y	Sumycin	❑Y ❑N	Grisovin	❑Y ❑N
❑N		Folex	❑Y ❑N	Ledermycin	❑Y ❑N
Demecocycline	❑Y ❑N	Ledertrexate	❑Y ❑N	Cyclidox	❑Y ❑N
Doxycycline	❑Y	Methotrexate Sodium	❑Y ❑N	Doxycyl or Doxytab	❑Y ❑N
❑N Doryx		PF	❑Y ❑N	Noritet	❑Y ❑N
❑Y ❑N		Aratac	❑Y ❑N	Vibramycin	❑Y ❑N
Dumoxin	❑Y	Pacerone	❑Y ❑N	Minocycline	❑Y ❑N
❑N		Amioderone	❑Y ❑N	Minomycin or Minotabs	❑Y ❑N
Viacin	❑Y	Codarone X	❑Y ❑N	Terramycin	❑Y ❑N
❑N		Terra-Cortril	❑Y ❑N	Cotet	❑Y ❑N
Lymecycline	❑Y	Trexall	❑Y ❑N	Quinolone Derivatives	❑Y ❑N
❑N		Methotrexate	❑Y ❑N	Nalidixic Acid	❑Y ❑N
Tetrasal	❑Y	LPF	❑Y ❑N	Oflaxacin	❑Y ❑N
❑N		Mexate AQ	❑Y ❑N	Achromycin or Acromysin V	❑Y ❑N
Cyclimycin	❑Y	Thorazine	❑Y ❑N	Bristacycline	❑Y ❑N
❑N		Tetrex	❑Y ❑N	Helidac	❑Y ❑N
Oxytetracycline Be-oxytet	❑Y ❑N	Azathioprine	❑Y ❑N	Chlorpromazine HC	❑Y ❑N
Oxypan	❑Y ❑N	Roaccutane	❑Y ❑N	Largactil	❑Y ❑N
Ciprofloxacin	❑Y ❑N	Isotretinoin Accutane	❑Y ❑N		

Other Current Medications/Vitamins/Hormones NOT listed above

_____

_____

By signing below, you assume full responsibility to inform Richmond Weight Loss of any changes in medical status.

Patient Signature: _____ Date: _____