Glendora Wellness
MEDICAL WEIGHT LOSS CENTER

Date: ___________________________ Email address: _______________________________________

PATIENT HEALTH HISTORY FORM

Last name: _____________________ First name: _____________________ Marital status: __________

Date of birth: ___________________ Age: ______ Height: _______ Weight: ________ Sex: _______

Street Address: ____ Home phone# _______________________

____ Cell phone # ________________________

City: ____ State: ________ Zip: ________________

Occupation: ____ Employer: __________________________

Physician name: ____ Physician #: _______________________

Physician address: ______________________________________ City: ________________ State: _________

Referred by: ___________________ Current medical condition(s):_________________________________

Current medications: ____

IN CASE OF EMERGENCY

Emergency Contact Name: ________________________ Relationship to patient: ____________________

Home phone # ___________________________________ Work phone # ____________________________