Personal Information

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth: _____

Address _____
Street City State Zip

Home Phone_____ Work Phone_____ Cell_____

Email: _____ Sex_____ Marital Status_____Maiden Name_____

Spouse's Name_____ Tel _____

Emergency Contact_____Tel_____Relationship_____

HOW DID YOU HEAR ABOUT US----------

RELATIVE/FRIEND (PLEASE WRITE THE NAME)----------
RADIO----------
INTERNET----------
OTHER----------

Information and Assignment of Benefits

I authorize the release of medical information to my primary care physician, referring physician, or consults if needed. I understand that payment is required for all services at the time they are rendered. Please note that RightWeight Clinics will not present a bill to any insurance company for its services. RightWeight will provide you a receipt for your visit and will not complete any specific forms that the insurance companies provide.

I certify that the information I have reported above is correct. I had the opportunity to ask questions regarding this issue. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Signature_____ Date_____

Last Name: _____ First Name:_____ DOB:_____

Medical Condition	Current Medications	Drug Allergies	Type of Reaction	Hospitalization/surgery	
Please say NO if none	**Please say NO if none**	**Please say NO if none**	**Please say NO if none**	Date	Reason

Do you currently take MAOI's (Nardil, Parnate, Selegine) or SSRI's (Prozac, Zoloft, Celexa, Paxil, Lexapro, Cymbalta, Effexor, Luvox) for depression or any other Psychiatric Disorder?

If so, when was the last time you took it?

Medical History/Symptoms – This information is required in order for us to know if Phentermine is contraindicated for you.
Please CIRCLE Yes or No to all medical conditions that you have been diagnosed before.

Congestive Heart Failure	YES OR NO	History of Rheumatic Fever	YES OR NO
Heart Murmur	YES OR NO	Insomnia	YES OR NO
Peripheral Vascular Disease/Cardiovascular Disease	YES OR NO	Sexual Dysfunction	YES OR NO
Other Heart Condition	YES OR NO	Dizziness/Fainting	YES OR NO
Depression	YES OR NO	Chest Pains	YES OR NO
Psychiatric Disorder	YES OR NO	Heart Palpitations	YES OR NO
Hypertension	YES OR NO	Shortness of Breath	YES OR NO
Glaucoma	YES OR NO	Miagraine/Other Headaches	YES OR NO
Thyroid Disease	YES OR NO	Have you had any drug or alcohol addictions?	YES OR NO
Liver Disease	YES OR NO		
Kidney Disease	YES OR NO		
Stroke	YES OR NO		

Women Only ***Pregnant?*** **Yes / No** ***Nursing?*** **Yes / No**

Social History

Coffee:	Cups Daily	
	Other Caffeine	
Alcohol/Drug Use	Type	
	Amount	

Patient Signature:_____ **Todays Date**_____