ShapeFast

Weight Loss Center LLC.

(301)390-4404 Main
(301)390-4973 Fax

Today's Date____________________

Name:____

Address:____
Street City State Zip

Date of Birth________ Age______ Height_______ Weight ________ Goal________

Home Phone____________________ Cell Phone_________________________

Employer Name___________________ Work Phone_______________________

Occupation_____________________ E-mail Address_______________________

Are you presently under a doctor's care for any reason? Yes No
If yes, please explain____

Have you had surgery in the past two years? Yes No
If yes, please explain____

Are you allergic to any medication? Yes No
If yes, please explain____

Are you allergic to any medication containing Sulfa? Yes No

Are you currently taking any medication? Yes No
If yes, please explain____

Are you pregnant or nursing? Yes No
If yes, please explain____

Do you or any family member have a history of:

	You	Family		You	Family		You	Family
Rheumatic fever			Asthma			Diabetes		
Kidney Stones			Heart Attack			Tb		
Convulsions			Arthritis			Rheumatism		
Pleurisy			Gout			Hepatitis		
Ulcer			Anemia			Mental Illness		
Stroke			Colitis			Tumors		
Urinary disorder			Epilepsy			Endometriosis		
High Blood Pressure			Cancer			Type ____________		

Who may we thank for referring you?____