

Dr. Robert Weitzner, M.D.
Prescriptive Weight Loss Center
970 Park Avenue
New York, NY 10028
(212) 737-4644

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Work Telephone: _____

Email: _____

Occupation: _____

Date of Birth: _____ Age: _____

How did you first hear of the program? _____

Referred By: _____

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Name: _____

Married: _____ Single: _____

Date of Birth: _____ Height: _____

No. of Children: _____ Ages: _____

Please answer all questions by checking the appropriate answer. Explain if needed.

	YES	NO		YES	NO
1. Have any members of your immediate family had:			4. Do you have:		
Diabetes	_____	_____	Difficulty Sleeping	_____	_____
Heart attach before age 55	_____	_____	Anxiety State	_____	_____
Strokes before age 55	_____	_____	Frequent Emotional Upset	_____	_____
High Blood Pressure	_____	_____	5. Are you taking any medication:		
Cancer (Type: _____)	_____	_____	Blood Pressure Medication	_____	_____
Mental Health Problems	_____	_____	Heart Medication	_____	_____
Overactive Thyroid	_____	_____	Stomach Medication	_____	_____
2. Have you ever had:			Pain Medication	_____	_____
Diabetes	_____	_____	Tranquilizers	_____	_____
High Blood Pressure	_____	_____	Hormones	_____	_____
Strokes	_____	_____	Laxatives	_____	_____
Blood Clots	_____	_____	Other	_____	_____
Underactive Thyroid	_____	_____	List _____		
Overactive Thyroid	_____	_____	6. Is/Was your mother overweight?	_____	_____
Glaucoma	_____	_____	If so, how much? _____		
Malignancies	_____	_____	Is/Was your father overweight?	_____	_____
Peptic Ulcer	_____	_____	If so, how much? _____		
Frequent Diarrhea	_____	_____	Is your spouse overweight?	_____	_____
Gallstones	_____	_____	If so, how much? _____		
Kidney Infections	_____	_____	7. What is the most you ever weighed? _____		
History of alcohol abuse	_____	_____	What was your minimum adult weight? _____		
History of drug abuse	_____	_____	At what age did you become overweight? _____		
Nervous Breakdown	_____	_____	Explain any aggravating cause _____		
Uncontrolled Shaking	_____	_____	_____		
Seizures	_____	_____	What methods of weight loss have you tried before? _____		
3a. Have you ever experienced:			_____		
Irregular heartbeats	_____	_____	_____		
Rapid pulse rate	_____	_____	_____		
Chest Pain	_____	_____	_____		
Blood Clots	_____	_____	_____		
Swelling of legs and/or ankles	_____	_____	_____		
Leg cramps	_____	_____			
3b. Have you ever had a Cardiogram?	_____	_____			
If so, date performed _____					
Result _____					
Have you ever had any severe illness?	_____	_____			
If so, specify _____					
Do you smoke?	_____	_____			
How many packs per day? _____					
For how many years? _____					

	YES	NO
8. Do you drink:		
Tea	_____	_____
Coffee	_____	_____
Soft drinks	_____	_____
Juice	_____	_____
Alcohol	_____	_____
How many drinks per week? _____		
For how many years? _____		
Do you eat breakfast?	_____	_____
lunch?	_____	_____
dinner?	_____	_____
Do you eat late at night?	_____	_____
Do you watch TV or read during meals? ...	_____	_____
Do you binge?	_____	_____
Who does the shopping? _____		
Who plans the meals? _____		
No. of people living in home _____		
How many of them are children? _____		
Do you eat late at night?	_____	_____
Do you eat more when you are depressed? _____		
How often do you eat out per week?	_____	_____
Do you induce vomiting after eating?	_____	_____
For how long have you done this?	_____	_____
9. What do you think triggers your appetite? _____		

10. Do you have:		
Hair loss	_____	_____
Thinning hair	_____	_____
Brittle nails	_____	_____
Dry skin	_____	_____
Itchy skin	_____	_____
Skin rashes	_____	_____
Swollen ankles	_____	_____
Nose bleeds	_____	_____
Bleeding gums	_____	_____
Dental infections	_____	_____
Sore mouth	_____	_____
Daytime drowsiness	_____	_____
Faint spells	_____	_____
Dizziness	_____	_____
Insomnia	_____	_____
Headaches	_____	_____
Sweating	_____	_____
Frequent colds	_____	_____
Sinus trouble	_____	_____
Asthma	_____	_____
Hayfever	_____	_____
Shortness of breath	_____	_____
Allergies to Medication	_____	_____
What do you think triggers your appetite? _____		

	YES	NO
11. Do you have:		
Poor digestion	_____	_____
Bloating	_____	_____
Heartburn	_____	_____
Stomach Gas	_____	_____
Stomach Pain	_____	_____
Poor Bowel Action	_____	_____
Loose bowels	_____	_____
Rectal Bleeding	_____	_____
12. For Women:		
Do you menstruate?	_____	_____
If not, how many years since		
your last cycle? _____		
Frequency: every _____ days		
Duration: lasts for _____ days		
Scanty?	_____	_____
Heavy?	_____	_____
Do you experience headaches and/or		
cramps with menstruation?	_____	_____
If so, how severe? _____		
Is there an increase in appetite		
at this time?	_____	_____
Are you currently taking birth		
control pills?	_____	_____
Do you get hot flashes?	_____	_____
Were any of your children heavier than		
9 lbs. when born?	_____	_____
List any surgery you've had and the date it was done _____		

Do you have any additional medical history that you		
would like to report? _____		

Date: _____		
Signature: _____		