

**ROBERT SKVERSKY, M.D., INC. – WEIGHT NO MORE**

320 SUPERIOR AVENUE - #210  
NEWPORT BEACH, CA 92663  
OFFICE: (949) 645-2930  
FAX: (949) 645-1059

28441 RANCHO CALIFORNIA RD. #104  
TEMECULA, CA 92590  
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**PATIENT INFORMATION – PLEASE PRINT CLEARLY**

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ SOC. SEC.#: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ SEX (CIRCLE): M OR F

CITY: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ AGE: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ FRAME: \_\_\_\_\_ DRIVER'S LICENSE: \_\_\_\_\_

**EMPLOYER INFORMATION – (PARENT INFORMATION IF PATIENT IS A MINOR)**

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER CITY: \_\_\_\_\_ EXTENSION: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**ADDITIONAL INFORMATION – PERSON TO NOTIFY IN CASE OF EMERGENCY**

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

MEDICATIONS YOU TAKE: (Name, how often, dosage)

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

\_\_\_\_\_

***I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF TREATMENT. I UNDERSTAND THAT WEIGHT NO MORE DOES NOT BILL ANY INSURANCE COMPANIES AND THEREFORE, I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES.***

\_\_\_\_\_  
**PATIENT SIGNATURE**

## MEDICAL HISTORY

### MEDICAL: HAVE YOU EVER BEEN TOLD THAT YOU HAD

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> HYPERTENSION    | <input type="checkbox"/> HEART DISEASE        | <input type="checkbox"/> ULCERS      |
| <input type="checkbox"/> DIABETES        | <input type="checkbox"/> ANGINA               | <input type="checkbox"/> DEPRESSION  |
| <input type="checkbox"/> TUBERCULOSIS    | <input type="checkbox"/> HEART ATTACK         | <input type="checkbox"/> EMPHYSEMA   |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> KIDNEY DISEASE       | <input type="checkbox"/> ARTHRITIS   |
| <input type="checkbox"/> DIVERTICULITIS  | <input type="checkbox"/> HYPERCHOLESTEROLEMIA | <input type="checkbox"/> OTHER _____ |
|  | <input type="checkbox"/> ASTHMA               | _____                                |

HAVE YOU HAD AN ELECTROCARDIOGRAM DONE IN THE PAST YEAR? YES \_\_\_\_\_ NO \_\_\_\_\_

### SURGERIES

### AGE / YEAR PERFORMED

TONSILS AND ADENOIDS \_\_\_\_\_

APPENDECTOMY \_\_\_\_\_

OTHER: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### HOSPITALIZATIONS:

### OTHER THAN SURGERIES NOTED ABOVE

\_\_\_\_\_  
\_\_\_\_\_

### FAMILY HISTORY:

### ALIVE / DECEASED

### AGE IF DECEASED

### CAUSE

FATHER \_\_\_\_\_

MOTHER \_\_\_\_\_

BROTHERS \_\_\_\_\_

SISTERS \_\_\_\_\_

CHILDREN \_\_\_\_\_

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\_\_\_\_\_

DO ANY ILLNESSES RUN IN THE FAMILY? IF YES, WHAT?

\_\_\_\_\_

### SOCIAL HISTORY:

DO YOU SMOKE? YES \_\_\_ NO \_\_\_ IF YES, FOR HOW MANY YEARS? \_\_\_\_\_  
HOW MANY PACKS A DAY HAVE YOU AVERAGED OVER THOSE YEARS? \_\_\_\_\_

DO YOU DRINK ALCOHOL? YES \_\_\_ NO \_\_\_  
DO YOU DRINK COFFEE? YES \_\_\_ NO \_\_\_ REGULAR \_\_\_ DECAF \_\_\_ CUPS/DAY \_\_\_\_\_  
DO YOU EXERCISE? YES \_\_\_ NO \_\_\_ IF YES, TYPE AND FREQUENCY? \_\_\_\_\_

ARE YOU PREGNANT? YES \_\_\_ NO \_\_\_  
DO YOU PLAN ON PREGNANCY IN THE NEXT 3 MONTHS: YES \_\_\_ NO \_\_\_