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

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

31537 RANCHO PUEBLO ROAD - #105
TEMECULA, CA 92592
OFFICE: (951) 699-0848
FAX: (951) 699-0509

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

- ❑ **HYPERTENSION**
- ❑ **DIABETES**
- ❑ **TUBERCULOSIS**
- ❑ **RHEUMATIC FEVER**
- ❑ **DIVERTICULITIS**
- ❑ **HEART DISEASE**
- ❑ **ANGINA**
- ❑ **HEART ATTACK**
- ❑ **KIDNEY DISEASE**
- ❑ **HYPERCHOLESTEROLEMIA**
- ❑ **ASTHMA**
- ❑ **ULCERS**
- ❑ **DEPRESSION**
- ❑ **EMPHYSEMA**
- ❑ **ARTHRITIS**
- ❑ **OTHER**_____

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	_____	_____	_____

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____