

ShapeFast

Weight Loss Center LLC.

(301)390-4404
Fax (301)390-0706

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 doctors 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? _____