

**Bridlewood Family Healthcare, P.A.**  
**hCG WEIGHT LOSS PROGRAM FORM**

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

**TODAY'S DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_ **DATE OF LAST PHYSICAL EXAM** \_\_\_\_/\_\_\_\_/\_\_\_\_

**LAST NAME** \_\_\_\_\_ **FIRST NAME:** \_\_\_\_\_

**SOCIAL SECURITY No.** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **AGE** \_\_\_\_\_

When did you first become overweight? (your age then) \_\_\_\_\_ (year) \_\_\_\_\_

How did your weight gain start? Describe any circumstances: \_\_\_\_\_

What do you think is the cause of your weight problem? \_\_\_\_\_

Your present weight: \_\_\_\_\_ your weight goal: \_\_\_\_\_ height: \_\_\_\_\_

What was your highest weight? (excluding pregnancy) \_\_\_\_\_ your age then \_\_\_\_ # of years ago \_\_\_\_\_

What was your lowest weight? \_\_\_\_\_ your age then \_\_\_\_\_ # of years ago \_\_\_\_\_

Have you ever stayed the same weight for 10 years or more? Yes:/ No

Have you attempted to lose weight before? \_\_\_\_\_ most lbs lost: \_\_\_\_\_ how long it took: \_\_\_\_\_

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, etc) and describe your results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where and when do you do most of your overeating? \_\_\_\_\_  
\_\_\_\_\_

Please make any comments that you think might be helpful: \_\_\_\_\_  
\_\_\_\_\_

Do you currently have any medical concerns? Please List: \_\_\_\_\_  
\_\_\_\_\_