Medi-Weight & Hydrate, LLC

NAME: _____ BIRTHDAY: _____ M_____F_____

ADDRESS: _____ DL#:_____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

EMPLOYER: _____ EMAIL: _____

RESPONSIBLE FOR BILL: _____ REFERRED BY:_____

MEDICAL HISTORY:

DIABETES	Y_____ N_____
BLOOD PRESSURE	Y_____ N_____
HEART ISSUES	Y_____ N_____
THYROID	Y_____ N_____
SEIZURE	Y_____ N_____
EPILEPSY	Y_____ N_____
STROKE	Y_____ N_____
ANEMIA	Y_____ N_____
HEPITITIS	Y_____ N_____
ANXIETY	Y_____ N_____
DEPRESSION	Y_____ N_____
OTHERS:	Y_____ N_____

LIST OTHERS: _____

_____

_____

HISTORY OF OPERATIONS:

_____

_____

_____

_____

ALL MEDICATIONS (INCLUDING OVER THE COUNTER)

_____

_____

_____

_____

DRUG ALLERGIES: _____

_____

LAST MENSTRUAL CYCLE: _____

SMOKING	Y_____ N_____
ALCOHOL	Y_____ N_____
STREET DRUG USE	Y_____ N_____

I HAVE COMPLETED THIS FORM WITH HEALTH DISCLOSURE INFORMATION THAT IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MEDI-WEIGHT & HYDRATE, LCC WILL NOT BE HELD MEDICALLY RESPONSIBLE FOR ANY OMITTED INFORMATION. I UNDERSTAND THAT MEDI-WEIGHT AND HYDRATE, LLC HAS THE RIGHT TO DENY PARTICIPATION FOR ANY REASON, MEDICAL OR OTHERWISE. I AGREE TO NOTIFY MEDI-WEIGHT & HYDRATE, LLC OF ANY CHANGES TO MY MEDICATIONS, HEALTH AND/OR FITNESS THAT MAY OCCUR BEFORE OR DURING THE PROGRAM.

SIGNATURE: _____ DATE: _____