SAPPHIRE WELLNESS PRECONSULTATION FORM **Please complete and bring to your first appointment**

PATIENT INFORMATION

How did you hear about us?

Last Name:		First Name:		M.I.	☐Male ☐Female
Date of Birth:	Age:	Mailing Address			
Email:		Home Phone #:	Cell Phone #:	Preferred Method of Communication: ☐ email ☐ phone ☐ mail	
Primary Care Physician				Phone #	

MEDICATIONS/SUPPLEMENTS

Please list ALL medications, prescribed or over the counter, including birth control medications and ALL supplements or vitamins that you take on a regular basis:

MED/SUPPLEMENT	COMMENTS

MEDICAL HISTORY Have you ever been diagnosed with any of the following:

Diabetes (Type 1, 2 or pregnancy related)	☐Yes	☐No	Stroke/Seizure	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Gallstones	☐Yes	☐No
Heart Disease/Failure	☐Yes	☐No	Liver Disease/Hepatitis	☐Yes	☐No
Back/Joint Pain (arthritis)	☐Yes	☐No	Glaucoma	☐Yes	☐No
Sleep Apnea or Snoring	☐Yes	☐No	Erectile Dysfunction	☐Yes	☐No
Reflux or Heartburn	☐Yes	☐No	Urinary Incontinence	☐Yes	☐No
Headaches (any type)	☐Yes	☐No	Addictive Disorders	☐Yes	☐No

Other:

WEIGHT INFORMATION AND HISTORY Please list all weight loss methods attempted and pounds lost

Weight Loss Program	Total Weight Lost

What has been the greatest obstacle to you achieving weight loss?

How much weight do you hope to lose? ________________ lbs (approximate)

How much would you ideally like to weigh? ________________ lbs (approximate)

What do you think will be the hardest thing to change while losing weight and getting healthier?

What are your goals and expectations for weight loss and maintenance?