Z-Weight Loss, LLC – MEDICAL ELIGIBILITY FORM

28230 N. Tatum Blvd, Suite C-4, Cave Creek, Arizona 85331 / 480-570-9200

LAST NAME FIRST NAME DATE

ADDRESS CITY STATE ZIP

TELEPHONE # (HOME) WORK CELL

DATE OF BIRTH AGE SEX MARITAL STATUS OCCUPATION SOCIAL SECURITY NUMBER

NAME OF EMERGENCY CONTACT/ TELEPHONE NUMBER EMAIL ADDRESS

DIET HISTORY:

1. How did you hear about the Program?_____

2. Have you tried other programs? _____ 3. How many times a do you eat?_____

4. Do you snack? _____ 5. Do you eat sweets? _____

6. Are you serious about losing weight? _____ 7. Why Now? _____

8. What is your most important reason for losing weight? _____

MEDICAL HISTORY (check all that apply)

	Depression		Anorexia		Bulimia		Food Allergies
	Cancer		Seizures		Ulcers		Diabetes
	High Blood Pressure		Heart Disease		Liver Disease		Thyroid Disease
	Gallbladder Disease		Stroke		Kidney Disease		Kidney Infection
	Drug Abuse		Alcohol Abuse		Muscle Pain		Joint Pain
	Rapid Heart Beat		Visual Problems		Headaches		Insomnia
	Swollen Hand		Swollen Feet		Bloody Stool		Bloody Urine

FAMILY HISTORY:

List any family member (i.e. mother, father, aunt, grandparents, sister, etc.)

Weight Problem? _____

Heart Problem? _____ Diabetes? _____

High Blood Pressure? _____ Psychiatric Illnesses? _____

ALCOHOL / DRUG / TOBACCO USE:

Do you drink alcohol? _____ How Many? _____ More than 2/ Day? _____

Do you use drugs? _____ How Often? _____ What type? _____

Have you ever been treated for alcohol/drug dependency?_____ When? _____

Do you smoke? _____ Do you plan to stop while on the program? _____