Georgia Healthcare Services Weight Loss Program
155 Medical Way, Ste D ;Riverdale, GA 30274
Phone: 770-961-1997
Website: www.georgiahc.com

Medical History Form

Patient Information

- **Name: _____**
- **Date of Birth: _____Gender: _____**
- **Address: _____**
- **City: _____ State: _____ Zip Code: _____**
- **Phone Number: _____**
- **Email Address: _____**

Primary Care Physician (if applicable)

- **Name: _____**
- **Phone Number: _____**

Emergency Contact Information

- **Name: _____**
- **Relationship to Patient: _____**
- **Phone Number: _____**

Medical History

1. **Do you have any existing medical conditions? (e.g., diabetes, hypertension, etc.)**
   - **Yes / No (Please specify if yes): _____**
2. **Are you currently taking any medications or supplements?**

- **Yes / No (Please list all medications and supplements):**

  _____

3. **Have you had any surgeries or medical procedures in the past?**
   - **Yes / No (Please specify if yes):**

     _____
4. **Do you have any known allergies?**
   - **Yes / No (Please specify if yes):**

     _____
5. **Do you have a history of any of the following medical conditions?**
   - **Heart disease**
   - **High blood pressure**
   - **High cholesterol**
   - **Stroke**
   - **Diabetes**
   - **Thyroid disorders**
   - **Respiratory disorders (e.g., asthma, COPD)**
   - **Gastrointestinal disorders (e.g., acid reflux, irritable bowel syndrome)**
   - **Joint disorders (e.g., arthritis)**
   - **Mental health disorders (e.g., depression, anxiety)**
   - **Other (please specify):**

     _____

Family History

6. **Do you have a family history of any of the following medical conditions?**
   - **Heart disease**
   - **High blood pressure**
   - **High cholesterol**
   - **Stroke**
   - **Diabetes**
   - **Thyroid disorders**
   - **Cancer**
   - **Other (please specify):**

     _____

Lifestyle Factors

7. **Do you smoke or use tobacco products?**
   - **Yes / No**

8. **How would you describe your current level of physical activity?**
    - **Sedentary / Light / Moderate / Active**
9. **Do you engage in any regular exercise or physical activity? If yes, please describe.**
    - **Yes / No (Please specify if yes):**

      _____

Additional Information

10. **Is there any other medical information you believe is relevant for us to know?**

Signature

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that this information will be used to develop a personalized weight loss plan for me.

Patient Signature: _____ Date: _____