

North Star Medical Weight Management

Medical History

Do you have a history of the following diseases:

	Yes	No
High Blood Pressure	()	()
Diabetes	()	()
Kidney Disease	()	()
Anemia	()	()
Hypoglycemia	()	()
High Cholesterol	()	()
Others...please list	_____	

Height_____ Weight_____ Age_____

Please list your current medications and the dosages (please include vitamins):

If you have allergies, please list them:

Patient Name: _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail Address _____

Patient's signature: _____ Date: _____

Please complete this form and FAX to : 1-847-398-8360

For questions, call us toll-free : 1-888-251-2653 or local : 1-847-577-8854