Midlands Medical Wellness Center, LLC
200 Springtree Dr., Suite 200
Columbia, SC 29223
Phone: (803)223-9328 Fax: (866)243-4929
www.MidlandsMedWC.com

MEDICAL ELIGIBILITY FORM

Last name:_____First name:_____

Address:_____State:_____Zip:_____

Home#:_____work#:_____cell#:_____

DOB:_____age:_____gender:_____occupation:_____soc.sec.#_____

DIET HISTORY:

1. How did you hear about our program?
   _____
2. Have you tried other programs? _____
3. How many times a day do you eat? _____4. Do you snack?_____ 5. Do you eat sweets?_____
6. Are you serious about losing weight?_____
7. What is your most important reason for losing weight?_____

MEDICAL HISTORY(circle 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 disease	Muscle pain	Joint pain
Rapid heart beat	Visual problems	headaches	insomnia
Swollen hands	Swollen feet	Bloody stool	Bloody urine

FAMILY HISTORY: (List any family member i.e. mother, father, aunt, grandparents, sister, ect.)

Weight problem? _____Heart problem?_____

High blood pressure?_____diabetes?_____

Psychiatric illnesses?_____thyroid problems?_____

ALCHOHOL/DRUG/TOBACCO USE:

Do you drink alcohol?_____ How many?_____More than 2 daily?_____

Do you use drugs? _____How often? _____ What type? _____

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

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

MEDICATIONS:
Are you currently taking any prescription or non-prescription medications? What and how often?

_____

_____

ALLERGIES TO MEDICATIONS:_____

SERIOUS ILLNESSES:
Date Illness **Outcome**

_____

_____

FEMALES ONLY:
1. Are you pregnant?_____2. Are you nursing?_____3.Are your periods regular?_____

4.Are you taking fertility drugs?_____5. Number of pregnancies?_____

6. Current type of birth control?_____

****IF YOU BECOME PREGNANT WHILE ON THIS PROGRAM, IT WILL BE NECESSARY TO DISCONTINUE YOUR PARTICIPATION.****

PHYSICAL EXAM:
Client is informed that the physical examination that you will undergo is only a screening to begin the weight loss program. A complete physical examination including breast, pelvic, or prostate exams should be done by his/her primary physician.

I HAVE READ AND UNDERSTAND THE HEALTH CARE AND PHYSICAL EXAM INFORMATION. I HAVE ANSWERED ALL THE QUESTIONS TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE MMWC WEIGHT LOSS PROGRAM USES MEDICATIONS THAT MAY AFFECT OTHER MEDICATIONS I AM CURRENTLY TAKING. I AGREE TO DISCUSS MY ENROLLMENT IN THE PROGRAM WITH MY PHYSICIAN. I UNDERSTAND THAT IF MY PHYSICIAN DOES NOT FEEL THAT THE PROGRAM IS SUITABLE FOR MY HEALTH STATUS I WILL DISCONTINUE THE PROGRAM. I AGREE THE MMWC PROVIDER AND MY PRIMARY PHYSICIAN OF ANY CHANGES IN MY HEALTH STATUS.

****FEMALES ONLY**: I UNDERSTAND THAT IT IS NOT ADVISABLE TO BECOME PREGNANT WHILE ON THE PROGRAM. IF I BECOME PREGNANT, I WILL INFORM THE MMWC PROVIDER IMMEDIATELY.**

_____
Signature date

MMWC provider: I have reviewed all the client's information and have incorporated it into my examination.

_____
Signature date