DR GEOFF B. MONSOUR, M.D.
MEDICAL WEIGHT LOSS CENTER
NEW PATIENT

PENN HILLS OFFICE________ IRWIN OFFICE _______

PATIENT HISTORY AND PHYSICAL INFORMATION

DATE_______ NAME ________________________________BIRTHDATE________

ADDRESS____PHONE____________

AGE________ SEX_______ OCCUPATION_________________________________

PRIMARY CARE PHYSICIAN_________________________PHONE____________

CURRENT MEDICATIONS :	REASON:	MEDICATION ALLERGIES:

HOSPITALATION OR SURGERY

DATE & REASON ____
____

1. WHAT OVER-THE-COUNTER MEDICATIONS DO YOU TAKE? __________
____

2. HOW MANY MEALS DO YOU EAT PER DAY?_______ HOW MANY SNACKS?________

3. HOW MANY GLASSES OF WATER DO YOU DRINK DAILY?____________

4. DO YOU SMOKE? _________ IF YES, HOW MUCH?_____________

5. DO YOU DRINK COFFEE? IF YES, HOW MANY CUPS?___________

6. DO YOU DRINK ALCOHOL?_______IF YES, TYPE AND AMOUNT?_______

7. WOMEN ONLY: ARE YOU PLANNING ON BECOMING PREGNANT?_____ PREGNANT?________ BREASTFEEDING?________