

**DR. GEOFF MEDICAL WEIGHT LOSS
GEOFFREY B. MONSOUR, M.D.
NEW PATIENT INFORMATION**

NAME _____ **BIRTHDATE** _____ **AGE** _____

HEIGHT _____ **GOAL WEIGHT** _____ **ALLERGIES** _____

**PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING PRESCRIPTION,
OVER-THE-COUNT, VITAMINS AND HERBALS.**

HAVE YOU EVER TAKEN A DIET PILL IN THE PAST? _____

IF YES, WHAT AND WHEN _____

HOW DID YOU HEAR ABOUT DR GEOFF MEDICAL WEIGHT LOSS? _____

MAY WE CONTACT YOU BY MAIL OR PHONE? _____

-----PLEASE DO NOT WRITE BELOW THIS LINE-----

DATE _____ **BP** _____ **WEIGHT** _____ **BMI** _____

APPETITIE SUPPRESSANT _____

DIURETIC _____ **POTASSIUM** _____ **MULTIVITAMINS** _____

B12 INJECTION _____ **OTHER** _____

STAFF SIGNATURE _____

M.D. SIGNATURE/INITIALS _____