REAL RESULTS
Medical Weight Loss

Real Weight Loss
Results for life

Patient Information

Last Name_____ First Name_____ M.I. ____
Birth Date_____ Mailing Address _____
City_____ State _____ Zip _____
E Mail Address _____
Home Phone_____(May we leave a message at this number? Y/N)
Alt Phone_____(May we leave a message at this number? Y/N)
How did you hear about us?_____

Health Information

Primary Health Concerns

_____

Any Known Health Problems

_____

Past Surgeries

_____

Current Medications

_____

Current Supplements/vitamins

_____

Allergies (foods/drugs/environmental)

_____

Family History - major health problems (cancer, heart disease, obesity, diabetes, etc.)
Father_____
Mother_____
Siblings_____

By signing below I confirm that I have fully read over and filled out the above health history questionnaire truthfully and accurately. I will now certify that I am under the care of another physician for all other medical conditions. I will consult this physician for any other medical services. I have completely and accurately disclosed any medical conditions and treatments, including prescription and non-prescription medications and supplements. I am aware that a copy of the Practice Policies and Privacy Practices may be reviewed online and provided as a hard copy by request only. I have read and understand the practice policies. I acknowledge by signing that I have also reviewed the NOTICE OF POLICY PROCEDURES, PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS as posted online at www.realresultsforlife.com and do not require a paper copy at this time.By signing this form, I agree to comply with these policies, and provide consent for treatment by Dr. Mildred Santorufo D.O. and any designated assistants.

Signature_____Date_____