

*Beautiful*



**Weight Management Program**

**HCG Participation Questionnaire**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City and Zip \_\_\_\_\_

Hm. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Date of Birth \_\_\_\_\_

LMP or expected date(N/A if not applicable) \_\_\_\_\_

Allergies(food/medications) \_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

Do you have (or ever had) any of the following? Check all that apply

\_\_\_ AIDS

\_\_\_ Anemia

\_\_\_ Arthritis

\_\_\_ Auto Immune Deficiency

\_\_\_ Asthma

\_\_\_ Blood Disease

\_\_\_ Blood Transfusion

\_\_\_ Cancer

\_\_\_ Breast

\_\_\_ Ovarian

\_\_\_ Prostate

\_\_\_ Thyroid

\_\_\_ Uterine

\_\_\_ Other

\_\_\_ Chemotherapy/Radiation Therapy

\_\_\_ Dizziness/fainting

\_\_\_ Epilepsy

\_\_\_ Heart Disease

\_\_\_ High Blood Pressure

\_\_\_ Kidney Disease

\_\_\_ Lupus

\_\_\_ Nervous Disorder

\_\_\_ Stomach/Ulcer Problems

\_\_\_ Thyroid Problems

\_\_\_ Other Important Medical Conditions or History \_\_\_\_\_

\_\_\_ Diabetes

\_\_\_ Eating Disorder

\_\_\_ Family History of Cancer

\_\_\_ Hepatitis

\_\_\_ Infection(active)

\_\_\_ Liver Disease

\_\_\_ Mental Disorder

\_\_\_ Respiratory Problems

\_\_\_ Stroke

\_\_\_ Tuberculosis