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

_____

ALLERGIES TO MEDICATIONS? Please list: _____

SERIOUS ILLNESSES:		
DATE	**ILLNESS**	**OUTCOME**

HOSPITALIZATIONS:		
DATE	**REASON**	**OUTCOME**

FEMALES ONLY:
1. Are you Pregnant? _____ 2. Are you nursing? _____

3. Are your menstrual 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.

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 Z-WEIGHT LOSS PROGRAM USES MEDICATIONS THAT MAY AFFECT OTHER MEDICATIONS I AM CURRENTLY TAKING. I AGREE TO DISCUSS MY ENROLLMENT IN THE Z-WEIGHT LOSS 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 TO INFORM THE Z-WEIGHT LOSS 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 Z-WEIGHT LOSS PROVIDER IMMEDIATELY.

_____/_____
Signature Date

Z-Weight Loss Provider: I have reviewed all the client's information and have incorporated it into my examination.

_____/_____
Signature Date