

Patient Information and Health History

AIM Medical Weight Loss Centers, P.C.

Please complete all fields and check the applicable boxes.

Patient name: _____ Date: _____

1 Contact Information

Home address: _____

City / State / ZIP: _____

Preferred contact method: ☐ Phone ☐ Text ☐ Email ☐ Patient Portal

2 Emergency Contact

Name: _____ Relationship: _____

Phone: _____

3 Additional Information

How did you hear about AIM?

☐ Physician ☐ Friend/Family ☐ Search/Web ☐ Social Media ☐ Other: _____

4 Allergies

Medication / Food / Substance allergy: _____

Reaction: _____

☐ No known medication allergies

5 Surgery History

Any previous surgeries? ☐ No ☐ Yes ☐ Not applicable

If yes, describe: _____

6 Mental Health and Eating Behavior

Have you ever been diagnosed with an eating disorder? ☐ No ☐ Yes: _____

Are you currently receiving mental health treatment? ☐ No ☐ Yes: _____

Current Medications and Supplements

Patient name: _____ Date: _____

List all prescription medications, over-the-counter medications, vitamins, supplements, diabetes medications, and weight-loss medications.

Medication / Supplement	Dose	Frequency	Reason

If you need more space, attach an additional medication list with your name and date.