New Start
SLIMMING CLINIC

Patient Medical Form

Please complete in black ink and bring this form to your appointment, or return it to the clinic. All information is treated as confidential.

Your details

TITLE (MR / MRS / MISS / MS / MX / DR)

FORENAME(S)

SURNAME

DATE OF BIRTH

ADDRESS

POSTCODE

TELEPHONE

EMAIL

OCCUPATION

About you

PHYSICAL ACTIVITY LEVEL

DO YOU SMOKE?

☐ Yes ☐ No

If yes, how many a day:

PRESENT EATING HABITS / WEAKNESSES

HOW LONG HAVE YOU BEEN OVERWEIGHT?

HAVE YOU PREVIOUSLY USED APPETITE SUPPRESSANTS?

☐ Yes ☐ No

If yes, please give details:

Reproductive health

These questions relate to menstruation, pregnancy and contraception. Please complete only if they apply to you.

DATE OF LAST MENSTRUAL PERIOD

CYCLE

☐ Regular ☐ Irregular

NUMBER OF PREGNANCIES

NUMBER OF CHILDREN

CONTRACEPTION (IF ANY)

STERILISATION?

☐ Yes ☐ No

HYSTERECTOMY?

☐ Yes ☐ No

Medical history

Do you suffer from, or have you ever suffered from, any of the following? Tick Yes or No. If Yes, please give brief details on the line provided.

HIGH BLOOD PRESSURE OR HEART TROUBLE (E.G. HEART ATTACK, ANGINA)

☐ Yes ☐ No

If yes, details:

CHEST OR RESPIRATORY PROBLEMS

☐ Yes ☐ No

If yes, details:

DIABETES OR THYROID PROBLEMS

☐ Yes ☐ No

If yes, details:

URINE, BLADDER OR KIDNEY COMPLAINTS

☐ Yes ☐ No

If yes, details:

ALLERGIES

☐ Yes ☐ No

If yes, details:

GLAUCOMA

☐ Yes ☐ No

If yes, details:

EPILEPSY

☐ Yes ☐ No

If yes, details:

HEADACHES, MIGRAINES OR PALPITATIONS

☐ Yes ☐ No

If yes, details:

ANY DRUG DEPENDENCY OR ALCOHOL MISUSE

☐ Yes ☐ No

If yes, details:

EATING DISORDERS (E.G. ANOREXIA, BULIMIA)

☐ Yes ☐ No

If yes, details:

HAVE YOU EVER HAD SURGERY OR AN OPERATION?

☐ Yes ☐ No

If yes, details:

STOMACH ULCERS OR GASTROINTESTINAL PROBLEMS

☐ Yes ☐ No

If yes, details:

Medicines & wellbeing

ARE YOU CURRENTLY BREASTFEEDING?

☐ Yes ☐ No

DO YOU SUFFER FROM ANY OTHER MEDICAL CONDITION NOT LISTED ABOVE?

☐ Yes ☐ No

If yes, please describe:

DO YOU TAKE ANY DRUGS OR MEDICINES?

☐ Yes ☐ No

If yes, please list all, with doses:

HAVE YOU TAKEN ANY MEDICATION IN THE LAST FOUR WEEKS?

☐ Yes ☐ No

DO YOU EXPERIENCE PSYCHIATRIC PROBLEMS, ANXIETY OR DEPRESSION?

☐ Yes ☐ No

If you answered Yes above, please complete the following. Otherwise skip to the next section.

WHICH OF THESE APPLY?

DO YOU TAKE MEDICATION FOR THIS?

☐ Yes ☐ No

If yes, what medication and dose:

DATE MEDICATION LAST TAKEN (ONLY IF YOU TAKE MEDICATION)

DO YOU FEEL IN A LOW MOOD NOW?

☐ Yes ☐ No

WHEN DID YOU LAST FEEL LOW?

ARE YOU CURRENTLY SEEING A PSYCHIATRIST?

☐ Yes ☐ No

HAVE YOU EVER EXPERIENCED SUICIDAL THOUGHTS?

☐ Yes ☐ No

If you are struggling right now, please call us, or in a crisis dial 999 or the Samaritans free on 116 123.

Your GP & contact preferences

The General Medical Council requires New Start Slimming Clinic Ltd to inform your general practitioner with any treatment prescribed at this clinic. Therefore, if you receive any prescription medication, we shall send a letter via post to your GP following your consultation. We shall also follow this up with a phone call to ensure your GP has received our letter.

GP NAME / SURGERY

GP ADDRESS

GP TELEPHONE

WHERE DID YOU HEAR ABOUT US?

MAY WE CONTACT YOU BY EMAIL?

☐ Yes ☐ No

MAY WE CONTACT YOU BY TEXT MESSAGE?

☐ Yes ☐ No

MAY WE CONTACT YOU BY TELEPHONE?

☐ Yes ☐ No

Consent & declaration

Please read and tick each statement. It is an offence under the Misuse of Drugs Act 1971 to make a false statement to obtain controlled medicines.

☐ I confirm I have received and read the Patient Information Guide.

☐ I confirm I do not suffer from any medical condition other than those detailed on this form.

☐ I confirm I am not pregnant and understand I must not become pregnant during treatment.

☐ I am not receiving appetite suppressants from any other source.

- [ ] I will stop taking appetite suppressants if my GP prescribes another medicine not detailed here.
- [ ] I have been informed of possible side effects and understand I must tell the doctor if I experience any.
- [ ] The information I have given on this form is true and complete to the best of my knowledge.
- [ ] I understand I must bring valid photo ID to my appointment.

Consent to treatment

- [ ] Contraception has been advised and discussed, in particular where Mounjaro or Wegovy may be prescribed.

Patient: I have understood the treatment plan and possible side effects of the medication and have received a medication information leaflet.

Patient signature _____ Date _____

For clinic use

Doctor: I have explained the treatment plan and possible side effects of the medication.

Doctor's signature _____ Date _____

Medication form reviewed (absence of 3 months or more)

To be completed at the clinic. I confirm that my medical status remains unchanged since my last attendance.

Date	Patient signature	Doctor's signature