SYNERGENX
HEALTH & WELLNESS CLINIC

19073 I-45 South, Suite #145, Shenandoah, TX 77385
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*****CLINICAL USE ONLY*****			
Date:		**MRN:**	
Name: (Last, First)			
Height:	**Weight:**		**BMI:**
B/P:		**Pulse:**	
BMI	**PBF**	**ICW**	**ECW**
Waist to Hip Ratio:			

Welcome to SynergenX Health Clinic!

SynergenX Health & Wellness Clinic — Patient Registration Form

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Age:	**E-Mail Address:**	
Address:		
City:	**State:**	**Zip:**
Home Phone Number: ( )		**Cell Phone Number:** ( )

May we send you a text message reminder the day before your appointment? ☐ YES ☐ NO

How did you hear about SynergenX Health Clinic?
☐ Billboard ☐ Coupon ☐ Direct Mailing ☐ Employee ☐ Internet ☐ M.D./Doctor ☐ Other
☐ Newspaper ☐ Patient/Friend ☐ Radio ☐ Walk-In ☐ Rheumatic Fever ☐ Magazine

Did someone Refer you to SynergenX Health Clinic?	**Which Doctor, if any, referred you?**

Goal Weight: _____ When was the last time (if ever) you were at that weight? _____

Patient Health History

Have you had Comprehensive physical exam within the last 12 months? ☐ Yes ☐ No
Have you had an EKG in the last 12 months: ☐ Yes ☐ No
If Yes was it normal? ☐ Yes ☐ No

Women Only:
Date of last menstruation?
Are you currently on birth control?
Date of last well women exam:
Date of last mammogram:
Are you pregnant, trying for pregnancy or breastfeeding? ☐ Yes ☐ No

Allergies to Medications

Medication Name	Reaction

Prescribed Medications & Over-the-Counter drugs, dietary Supplements (including vitamins, inhalers etc)

Medication Name	Strength	Frequency

History of Cardiac Disorder / Event ☐ NONE	
☐ Myocardial infarction	Date:
☐ Cerebrovascular accident	Date:
☐ Thrombosis / Embolism	Date:
☐ Coronary artery bypass graft surgery / CABG	Date:
☐ Aortic valve disorder	Date:
☐ Mitral Valve Disorder	Date:
☐ Endocarditis	Date:
☐ Pericarditis	Date:
☐ Cardiomyopathy	Date:
☐ Cardiac conduction disorder (AV block, Bundle Branch block, Mobitz type II AV)	Date:
☐ Cardiac arrhythmia (Atrial fibrillation/flutter, Paroxsymal supraventricular tachycardia, etc.)	Date:
☐ Heart failure (congestive heart failure, etc.)	Date:

Past Medical History ☐ NONE	Check any that you ever had or been diagnosed with any below	
☐ Prior Hormone Replacement Therapy _____	☐ Diabetes I _____	☐ Anemia
	☐ Diabetes II _____	☐ Hemochromatosis
☐ Sleep Apnea: _____	☐ Hypothyroidism	☐ Bleeding disorder: _____
☐ Snoring	☐ Enlarged Thyroid	☐ Obesity
☐ Chronic Kidney Disease	☐ Enlarged Prostate	☐ Cottonseed Allergy
☐ Abnormal Liver function	☐ Hx of prostate cancer	☐ History of Seizures
☐ Heart Disease: _____	☐ Hypogonadism	☐ Cancer _____
☐ High Blood Pressure: _____	☐ Depression _____	☐ Cardiovascular Disease
☐ High Cholesterol _____		☐ Blood Clot (DVT/Pulmonary Emboli)
☐ Peripheral artery disease	☐ Anxiety	☐ Chest Pain
☐ Chronic Lymph node enlargement	☐ HIV	☐ Heart Attack
☐ Inability to father children despite unprotected sexual relations > 1 year	☐ Mumps	☐ Heart Failure (CHF)
	☐ Acid Reflux	☐ Stroke
☐ COPD	☐ Gout	☐ Other: _____
☐ Insomnia	☐ Headaches (frequent)	☐ Other: _____
FOR WOMEN ONLY		
☐ Endometriosis	☐ Fibroids	☐ Polycystic Ovarian Disease (PCOS)

Social History

Exercise

How often are you physically active for 20 minutes or longer?

☐ Never ☐ 1-2 x/week ☐ 3-4 x/week ☐ >5 x/week

Which type(s) of exercise do you do? (check all that apply)

☐ Walking ☐ Running ☐ Weights ☐ Other _____

Do you have any barriers that limit your ability to safely exercise? ☐ Yes ☐ No

Please check all that apply:

☐ Work ☐ Family ☐ Energy level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other _____

Caffeine

Rank your caffeine intake: ☐ High ☐ Medium ☐ Low ☐ None

What do typically drink during the day?

☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other:_____

How many cups/cans per day? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ☐ Beer ☐ Liquor ☐ Wine

How many drinks per week? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

How many meals do you eat on an average day?

Rank your salt intake ☐ High ☐ Medium ☐ Low

Rank your fat intake ☐ High ☐ Medium ☐ Low

Please check the appropriate column for each of the following questions:

	Never	Rarely	Sometimes	Often	Almost Always
Does your family eat meals together?					
Do you read the food labels/nutritional information when you shop for food?					
Does your nutritional information influence your decision to buy/eat certain foods?					
Do you eat in front of a TV?					
Do you eat with others?					
Do you eat when you are stressed?					
Do you eat when you are anxious?					
Do you eat when you are lonely?					
Do you eat when you are not hungry?					
Do you eat when you are bored?					

Lifestyle

How many hours do you typically sleep at night? _____

How long does it typically take you to fall asleep? _____

How many times, on average, do you wake up once you fall asleep? _____

Do you wake up most mornings feeling well rested? ☐ **Yes** ☐ **No**

Has anyone ever told you that you snore? ☐ **Yes** ☐ **No**

Weight History
1. What is the main reason you decided to lose weight?
2. When did you begin gaining excess weight (give reasons if known)?
3. What do you think is the main cause of your weight problems?
4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5. Is your spouse, fiancé, or partner overweight?
6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7. List any food allergies:
8. What foods do you avoid?
9. What foods do you crave?
10. Do you awaken hungry during the night?
11. What are your worst food habits?
12. What are your snack habits?
13. Rate your body from 1 to 10. How would you describe your body?
14. If you could change one thing about your body, what would it be?
15. What do you feel will be your obstacle(s) to successful weight loss?
16. What is your typical breakfast? What time? Where? With whom?
17. What is your typical lunch? What time? Where? With whom?
18. What is your typical dinner? What time? Where? With whom?
19. Add any additional comments you think would be helpful to the doctor.

Do you have a personal of family history of blood clots or any clotting disorder? _____

If you answered yes to any of the preceding questions regarding the gallbladder, ovarian cyst or blood clots, please read the following statements and sign in acknowledgement:

Gallbladder or gallstone statement:

I understand that any pre-existing gallbladder dysfunction or gallstones I have (whether or not I am aware of it) may become exacerbated due to the low-fat nature of the HCG Diet Program or as a consequence of the rapid weight-loss. This may result in the need to have my gallbladder surgically removed.

_____ _____
Patient Signature Date

Ovarian Cyst / Polycystic ovarian syndrome statement:

I understand that if I am predisposed to ovarian cysts or polycystic ovarian syndrome, there is an increased risk of a cyst rupture due to ovarian stimulation from the HCG hormone, which may or may not require surgery.

_____ _____
Patient Signature Date

Blood Clots statement:

I understand that HCG is a hormone that has the potential to increase the risk of blood clots in genetically susceptible people. If I have a personal or family history of blood clots, I accept this increased risk and agree to take asprin and other recommended supplements to try to counteract the blood clot risk.

_____ _____
Patient Signature Date

*****SynergenX Clinician Use Only*****

Physical Exam: _____

Impression / Diagnosis:

- ☐ Overweight
- ☐ Obese
- ☐ Metabolic Syndrome
- ☐ Dietary Counseling and surveillance
- ☐ Hypothyriodism
- ☐ Elevated B/P
- ☐ Hypertension
- ☐ Abnormal EKG
- ☐ Other: _____

BMI results: ICW:____ ECW:____ BMI:____ PBF:____% ECW/TBW analysis:_____

Waiste to Hip ratio:_____

EKG Results(if needed) : _____

Treatment: HCG: 23 Day / 40 Day Lipo C Inj Phentermine 37.5mg prescribed today

Recommended _____lbs of weight loss