Axia WOMEN'S HEALTH

ReVita' Life
239 Hurffville-Cross Keys Road
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Re-Vita' LIFE

HCG Weight Loss

Dear Patient,

Thank you for inquiring about HCG weight loss. You have made a choice to not only be a thinner, but healthier you! We'd like to give you some general information regarding the program and costs.

Your initial visit will include a consultation with the provider and a nurse at which time you will receive:

- A history and physical
- Review of labs
- Body Mass Index (BMI) assessment
- Goal weight analysis
- Height, weight and body measurements
- Your Re-Vita'Life HCG Weight Loss Kit

Following your initial consultation with the provider and nurse you will be seen every two weeks by the Nurse until you reach the transition phase. The transition phase lasts for 3 weeks and once completed you will be seen again by the provider or nurse. The final phase is maintenance which lasts for 4 weeks. Once you have completed that phase your will be seen again by the provider or nurse.

The cost of the Weight Loss Kit will depend on which plan your provider selects for your specific needs.

4 week sublingual plan $650
4 week injection plan $750
6 week injection plan $850
8 week injection plan $950

The kit provides the HCG, Probiotics and Vitamins you will need along with other items to support your weight loss goals. Please feel free to discuss any additional questions you may have with either the provider or Nurse.

We look forward to caring for you.

Cordially,

The Re-Vita'Life Team
Phone: 856-262-4750

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HCG WEIGHTLOSS PROGRAM

All information in this questionnaire will be kept completely confidential

Name (Last, First, M.I.): ☐M ☐F **Date:**

Address:

Street: _____

_____

City, State, Zip: _____

Email Address: _____

Phone Numbers: (Check preferred)

HOME: _____

CELL#: _____

WORK: _____

OTHER: _____

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: **BIRTHDATE:**

Primary Doctor: **Date of last physical exam:**

City/State/Phone #:

HOW DID YOU HEAR ABOUT US? Please be specific.

☐ Friend/Family: _____

☐ Doctor's Office: _____

☐ Advertisement: _____

☐ _____

☐ Internet Search: _____

What term(s) did you search? _____

_____

☐ Facebook/Twitter: _____

☐ Other: _____

PERSONAL HEALTH HISTORY

MEDICAL HISTORY AND DATES OF DIAGNOSIS

HAVE YOU HAD ANY RECENT BLOODWORK DONE, IF SO PLEASE LIST DATES AS WELL AS WHO ORDERED IT? (I.E. LAB CORP, QUEST)

SURGERIES:

Year	Reason	Hospital

Please Turn To Next Page

Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications, foods, or supplements:			
Name of Product	Reaction You Had	Name of Product	Reaction You Had

HEALTH HABITS AND SCREENING				
Goal	What is your weight loss goal?			
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	Number of meals you eat in an average day? _____			
Caffeine	☐ None	☐ Coffee, #cups _____	☐ Tea	☐ Cola, # cans _____
	How do you take your coffee – sweetener or cream?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	Do you use tobacco?		☐ Yes	☐ No
	Do you currently use recreational drugs?		☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐M ☐F	
Mother				☐M ☐F	
Sibling	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	

MENTAL HEALTH		
Do you have a history of substance abuse?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you been treated for depression?	☐ Yes	☐ No
Have you been treated for anxiety?	☐ Yes	☐ No
Have you been treated for bi-polar disorder?	☐ Yes	☐ No
Have you been treated for panic attacks?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have a history of an eating disorder?	☐ Yes	☐ No
Are you or have you been under psychiatric care?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
If you have answered "Yes" to any of the above questions, please explain:		

WOMEN ONLY		
Date of last menstruation:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Did you have nausea during your pregnancy?	☐ Yes	☐ No
Have you had a hysterectomy?	☐ Yes	☐ No
Date of last mammogram exam? Was it normal?		
Date of last pap exam? Was it normal?		

MEN ONLY
Date of last prostate exam?