



Aleksandr Benji FNP
98-71 Queens Blvd, Rego Park NY 11374
646-301-4000

Weight Loss Intake Form

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

ALLERGIES (Please list any food, drug, or medication hypersensitivities or allergies you experience. Please include reaction.)

\_\_\_\_\_
\_\_\_\_\_

Sulfa Allergy \_\_\_\_\_ Soy Allergy \_\_\_\_\_

Topical Anesthetic Allergy \_\_\_\_\_ Specify \_\_\_\_\_

MEDICATIONS

Current medications (vitamins, birth control pills) \_\_\_\_\_

\_\_\_\_\_

Mood-altering or depression medication \_\_\_\_\_

SKIN ASSESSMENT

Do you have any of the following concerns? (Check all that apply.)

- \_\_\_ Fine Lines \_\_\_ Deep Wrinkles \_\_\_ Under eye Circles \_\_\_ Sagging Skin
\_\_\_ Dark Spots \_\_\_ Rough skin texture \_\_\_ Large pores \_\_\_ Sagging cheek bones
\_\_\_ Stretch marks \_\_\_ Scars (acne or surgical) \_\_\_ None \_\_\_ Other:

MENSTRUAL / BIRTHING HISTORY

Is it possible you may be pregnant? Yes \_\_\_ No \_\_\_ If "Yes" How far along? \_\_\_\_\_

- Last Menstrual Cycle \_\_\_\_\_ Age of first Menses \_\_\_\_\_ Itching or burning \_\_\_ Yes \_\_\_ No
# of Pregnancies \_\_\_\_\_ # of Days of Menses \_\_\_\_\_ Bleeding between periods \_\_\_ Yes \_\_\_ No
# of Miscarriages \_\_\_\_\_ Length of Cycle \_\_\_\_\_ Bleeding after intercourse \_\_\_ Yes \_\_\_ No
# of Live Births \_\_\_\_\_ # of Abortions \_\_\_\_\_ Irritation or discharge \_\_\_ Yes \_\_\_ No

**FAMILY HISTORY** (Check all health conditions that apply.)

	<b>Father</b>	<b>Mother</b>	<b>Brother(s)</b>	<b>Sister(s)</b>
Age (if living)				
Health (G=Good / P=Poor)				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				
Asthma/Hay Fever/Hives				
Kidney Disease				
Age (at Death)				
Cause of Death				

**GENERAL HEALTH**

When and where did you last receive health care?

\_\_\_\_\_

For what reason? \_\_\_\_\_

Do you have any infectious diseases? Yes \_\_\_ No \_\_\_

If "Yes" Please Identify \_\_\_\_\_

What was your most recent blood pressure reading? \_\_\_\_/\_\_\_\_ Date taken \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you currently have any medical concerns? Please list \_\_\_\_\_

\_\_\_\_\_

Have You Been Able To Follow Prescribed Medications/Treatments? Yes \_\_\_ No \_\_\_

If "No" why not? \_\_\_\_\_

Have you been diagnosed with or had any of the following conditions (past or present)?  
Please check all that apply.

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Brain Fog              | <input type="checkbox"/> Neck Pain                          |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Back Pain                  | <input type="checkbox"/> Fever                      | <input type="checkbox"/> Shoulder Pain          | <input type="checkbox"/> Leg Pain                           |
| <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Spasms/Cramps                      |
| <input type="checkbox"/> Hot Flashes            | <input type="checkbox"/> Tendonitis                 | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Osteoporosis                       |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Abdominal Pain         | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Gas/Bloating               | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Thyroid Dysfunction                |
| <input type="checkbox"/> Epilepsy/<br>seizures  | <input type="checkbox"/> Numbness/<br>tingling      | <input type="checkbox"/> Constipation/<br>Diarrhea  | <input type="checkbox"/> Shortness of<br>Breath | <input type="checkbox"/> Arthritis/Stiff/<br>Painful Joints |
| <input type="checkbox"/> Rash/<br>skin problems | <input type="checkbox"/> Bladder/<br>Kidney Disease | <input type="checkbox"/> Sciatica/<br>Shooting pain |   |   |

Please provide more explanation about all that you checked.

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Have you been diagnosed with or had any of the following digestive disorders (past or present)?  
Please check all that apply.

- |  |   |                                       |   |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea            | <input type="checkbox"/> Vomiting       | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Blood in stool                   |
| <input type="checkbox"/> Bloating/Gas      | <input type="checkbox"/> ABD Distention | <input type="checkbox"/> Constipation | <input type="checkbox"/> Incomplete Evacuation            |
| <input type="checkbox"/> Small Round Stool | <input type="checkbox"/> Hard Stool     | <input type="checkbox"/> ABD cramping | <input type="checkbox"/> Significant Residual When Wiping |

### **DIGESTIVE HEALTH / BOWEL MOVEMENT (BM) CHARACTERISTICS**

Number of BM times per day:  1  2  3  4

If don't typically have a daily BM how often do you evacuate?

1-2 times per week  3-4 per week  5-6 per week  less than once a week

Does it feel like there is more feces stuck in you after having bowel movement?  Yes  No

Do you eat a diet low in fiber?  Yes  No

Does your diet include a lot of meat/cheese or processed foods?  Yes  No

Do you suffer from incontinence? \_\_\_Yes \_\_\_No

Do you experience pain upon defecation? \_\_\_Yes \_\_\_No

Do you experience blood in your stool? \_\_\_Yes \_\_\_No

Do you have hemorrhoids? \_\_\_Yes \_\_\_No

When was your last bowel movement? \_\_\_\_\_

What BM interventions do you use? \_\_\_None \_\_\_Laxatives \_\_\_Enemas \_\_\_Other\_\_\_\_\_

### EXAMINATIONS HISTORY

Date of last physical examination \_\_\_\_\_ Reason \_\_\_\_\_

Hospitalization Dates and Reasons \_\_\_\_\_

X-Rays: \_\_\_Chest \_\_\_Stomach \_\_\_Gallbladder \_\_\_Kidney \_\_\_Colon \_\_\_Other\_\_\_\_\_

Date of last laboratory tests \_\_\_\_\_

Data of last electrocardiogram (heart tracing) \_\_\_\_\_

Date of last pap (cancer smear) \_\_\_\_\_

### WEIGHT HISTORY

When did you first become overweight? (Year) \_\_\_\_\_ (Your age then) \_\_\_\_\_

How did your weight gain start? Describe the circumstances \_\_\_\_\_

What do you think is the cause of your weight problem? \_\_\_\_\_

Your present weight \_\_\_\_\_ Your weight goal \_\_\_\_\_ Your height \_\_\_\_\_

What was your highest weight? (excluding pregnancy) \_\_\_\_\_ Your age then \_\_\_\_\_

What was your lowest weight? \_\_\_\_\_ your age then \_\_\_\_\_ # of years ago: \_\_\_\_\_

Have you ever stayed the same weight for 10 years or more? \_\_\_Yes \_\_\_No

Have you attempted to lose weight before? \_\_\_Yes \_\_\_No

Most lbs lost \_\_\_\_\_ How long it took \_\_\_\_\_

Describe your previous weight loss methods (e.g. diets, pills, injections, hypnosis, acupuncture) and results

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## ENERGY AND IMMUNITY

Do you have any of the following concerns? (Check all that apply.)

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Slow Wound Healing | <input type="checkbox"/> Chronic Infections         |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Candida / Yeast Infections |

## EMOTIONAL/PSYCHIATRIC

Do you have any of the following concerns? (Check all that apply.)

- |                                       |                                      |   |
|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Mood Swings  | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mental Tension |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression  | <input type="checkbox"/> Grief          |

## HEAD, EYE, EAR, NOSE, THROAT

Do you have any of the following concerns? (Check all that apply.)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Impaired Vision  | <input type="checkbox"/> Eye Pain/ Strain      | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Ear Ringing           | <input type="checkbox"/> Earaches       | <input type="checkbox"/> Headaches        |
| <input type="checkbox"/> Nose Bleeds      | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> TMJ/Jaw Problems |
| <input type="checkbox"/> Tearing/Dryness  | <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Hay Fever      |   |

## RESPIRATORY

Do you have any of the following concerns? (Check all that apply.)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Frequent Common Colds | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Shortness of Breath  |

## CARDIOVASCULAR

Do you have any of the following concerns? (Check all that apply.)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> High BP Palpitations |
| <input type="checkbox"/> Fluttering      | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Bruising           | <input type="checkbox"/> Heart Murmurs        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Abnormal Bleeding  | <input type="checkbox"/> Pain in Calves       |

## GASTROINTESTINAL

Do you have any of the following concerns? (Check all that apply.)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Changes In Appetite | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Epigastric Pain |
| <input type="checkbox"/> Heartburn      | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> Hemorrhoids     |
| <input type="checkbox"/> IBS            | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Abdominal Pain  | <input type="checkbox"/> Passing Gas     |
| <input type="checkbox"/> Diverticulitis |  |  |  |

**GENITO-URINARY TRACT**

Do you have any of the following concerns? (Check all that apply.)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> Frequent UTI   |
| <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Impaired Urination          | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Frequent Urination at Night | <input type="checkbox"/> Heavy Flow     |

**FEMALE REPRODUCTIVE / BREASTS**

Do you have any of the following concerns? (Check all that apply.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Irregular Cycles    | <input type="checkbox"/> Breast Lumps/ Tenderness | <input type="checkbox"/> Difficulty Conceiving   |
| <input type="checkbox"/> Vaginal Discharge   | <input type="checkbox"/> Premenstrual Problems    | <input type="checkbox"/> Bleeding Between Cycles |
| <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Clotting                 | <input type="checkbox"/> Heavy Flow              |
| <input type="checkbox"/> Nipple Discharge    | <input type="checkbox"/> Painful Periods          |  |

**MALE REPRODUCTIVE**

Do you have any of the following concerns? (Check all that apply.)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Testicular Pain/Swelling | <input type="checkbox"/> Penile Discharge |
|---|--|---|---|

**MUSCULOSKELETAL**

Do you have any of the following concerns? (Check all that apply.)

- |  |   |                                   |  |
|--|---|-----------------------------------|--|
| <input type="checkbox"/> Neck/Shoulder   | <input type="checkbox"/> Muscle Spasms/Cramps | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Joint Pain      |

**NEUROLOGIC**

Do you have any of the following concerns? (Check all that apply.)

- |  |                                    |  |  |  |
|--|------------------------------------|--|--|--|
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Seizures/Epilepsy |
|--|------------------------------------|--|--|--|

**ENDOCRINE**

Do you have any of the following concerns? (Check all that apply.)

- |                                      |                                       |  |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hyperthyroid        |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Feeling Hot or Cold |

**LIFESTYLE**

Do you typically eat at least three meals per day? \_\_\_Yes \_\_\_No

If "No" why not? \_\_\_\_\_

Describe your exercise routine \_\_\_\_\_

Describe your spiritual practice \_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? \_\_\_Yes \_\_\_No

Level of education completed: \_\_\_High School \_\_\_Bachelors \_\_\_Masters \_\_\_Doctorate \_\_\_Other

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work? \_\_\_Yes \_\_\_No Why or Why Not? \_\_\_\_\_

In the past or present, have you:

- used nicotine? \_\_\_Yes \_\_\_No If "Yes" what form? \_\_\_\_\_  
Amount \_\_\_\_\_ Frequency \_\_\_\_\_
- used alcohol? \_\_\_Yes \_\_\_No If "Yes" what form? \_\_\_\_\_  
Amount \_\_\_\_\_ Frequency \_\_\_\_\_
- used recreational drugs? \_\_\_Yes \_\_\_No If "Yes" what form? \_\_\_\_\_  
Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Have you experienced any major traumas? \_\_\_Yes \_\_\_No

If "Yes" please explain: \_\_\_\_\_

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

List your interests and hobbies \_\_\_\_\_

I \_\_\_\_\_ (patient name) acknowledge and understand that:

- 1) Aleksandr Benji FNP and Aesthetic Solutions NY is NOT my primary Medical Doctor;
- 2) All medical decisions regarding any current or future health conditions should be addressed by my primary care physician;
- 3) Aesthetic Solutions NY serves as only a resource for general well-being and preventive medicine and does NOT treat any existing illness;
- 4) All supplied information is accurate and forthcoming;
- 5) I have informed my primary care physician about services I am to receive at Aesthetic Solutions NY and he/she has no objections to such services.
- 6) I have not been rushed into making any decisions and I have had ample opportunities to ask Aleksandr Benji FNP and my primary care physician questions prior to receiving any treatment.
- 7) I acknowledge that Aleksandr Benji FNP/ Aesthetic Solutions NY does not provide any promises or guarantees that the treatments I am to receive will be effective in helping to improve my current health conditions and that in coming to Aesthetic Solutions NY, I had previously made a decision independent of Aesthetic Solutions NY to try the services offered at Aesthetic Solutions NY.
- 8) I understand that there are NO REFUNDS and state that I can afford the services I am seeking and that I have not been made any promises as to the results or effectiveness of such services/treatments.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME