Attending Physician Statement

Please submit this form and all related correspondence to:

Service Address
1901 Ponce De Leon Blvd.
Coral Gables, Fl 33134 USA

Customer Service: + 1 305.405.8929
U.S. Toll Free: + 1 800.222.3002
International Toll Free: + 1 844.596.2729
Fax: + 1 305.443.9671

app-info@weadirect.com
www.weadirect.com

PATIENT INFORMATION

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. First Name

2. Last Name

3. Date of Birth MM/DD/YYYY

4. Height ☐ Meters ☐ Feet

5. Weight ☐ Kilos ☐ Pounds

6. Waist Circumference ☐ Centimeters ☐ Inches

7. Hip Circumference ☐ Centimeters ☐ Inches

8. Has the patient used nicotine products? ☐ Yes ☐ No

8.a. If yes, what product(s)

8.b. Quantity

8.c. From MM/DD/YYYY

8.d. To MM/DD/YYYY

9. Please provide information about the patient's last 5 consultations:

Date	Reason of Consultation	Treatment	Blood Pressure
MM/DD/YYYY			
MM/DD/YYYY			
MM/DD/YYYY			
MM/DD/YYYY			
MM/DD/YYYY			

10. Has the patient had any surgery? ☐ Yes ☐ No — If Yes, explain reason

11. Has the patient been hospitalized? ☐ Yes ☐ No — If Yes, explain reason

12. Has the patient consulted with another physician? ☐ Yes ☐ No — If Yes, explain reason

13. Results of the following diagnostic testing

Name	Value	Date	Name	Value	Date
Hematocrit (%)		MM/DD/YYYY	HDL Cholesterol (mg/dL)		MM/DD/YYYY
Hemoglobin (g/dL)		MM/DD/YYYY	LDL Cholesterol (mg/dL)		MM/DD/YYYY
Erythrocytes (cells/mcL)		MM/DD/YYYY	Total Cholesterol (mg/dL)		MM/DD/YYYY
Leukocytes (cells/mcL)		MM/DD/YYYY	Triglycerides (mg/dL)		MM/DD/YYYY
Platelets (cells/mcL)		MM/DD/YYYY	Creatinine (mg/dL)		MM/DD/YYYY
Glucosa en Ayunas (mg/dL)		MM/DD/YYYY	PSA (ng/ml) Only men		MM/DD/YYYY
Hba1c (%)		MM/DD/YYYY	Urinalysis		MM/DD/YYYY

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PATIENT INFORMATION CONTINUED

14. EKG

15. ONLY WOMEN: Results of the last mammogram and Pap smear (performed in the last 12 months):

16. Results for any other tests that have been performed

17. Is there any family history of cardiovascular disease before 55 years of age?

☐ Yes

☐ No

If Yes, explain reason

18. Other risk factors, diseases, symptoms or complications not mentioned before

19. Additional Information

IN CASE OF HEART VALVE DISEASE, HEART MURMUR OR INFARCTION INCLUDE ECHOCARDIOGRAM RESULTS

PHYSICIAN INFORMATION

20. Name of the Attending Physician

21. Phone Number

22. Fax Number

23. Email

24. Skype

PHYSICIAN SIGNATURE

Physician Signature

Date of Signature

MM/DD/YYYY