Weight Loss New Patient Form

Name: _____Date: _____/_____/_____

WEIGHT HISTORY

· What is the reason for your visit today?_____
· What is your current weight? _____lbs. What is your weight loss goal? _____
· Please describe previous weight loss attempts:
_____
_ _____
· What is your highest weight? _____lbs. When was that? _____
· What is the lowest weight as an adult? _____lbs. When was that? _____
· What was your weight one year ago? _____lbs.
· What is the maximum amount of weight you've lost in the past? _____ lbs.
· What pattern best describes your weight over the past year?
☐ Gaining ☐ Losing ☐ Stable
· Have you ever had weight loss surgery?
☐ Gastric Bypass ☐ Lap Band ☐ Other ☐ None
· Have you ever taken medication for weight loss? NO☐ YES☐
- If YES, which medications and when:_____
· What are the biggest challenges you face in losing weight / maintaining weight loss?
_____
_____
_____

DIET HISTORY / EATING HABITS

· Do you follow any special diet or have diet restrictions/limitations for any reason (health, cultural, religious)? YES NO If so, please describe_____
· Do you have any food allergies? _____
· Do you currently/have you ever suffered from an eating disorder? NO YES
- If YES, please describe: _____
· Who prepares most of your meals?_____ Who shops for your food? _____
· How much alcohol do you drink in one week? _____
· How many meals per week do you eat in restaurants/order takeout? _____
. How many sweet beverages do you drink in one week?

· Which meal is your biggest: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ After Dinner
· On a regular basis, do you eat breakfast? YES ☐ NO ☐
· On a regular basis, do you eat lunch? YES ☐ NO ☐
· On a regular basis, do you eat dinner? YES ☐ NO ☐
· Do you feel out of control when eating? YES ☐ NO ☐
· Do you eat large volumes in a short time (binge)? YES ☐ NO ☐
· Is night eating a problem for you? YES ☐ NO ☐
· Do you get up after you have gone to bed to eat? YES ☐ NO ☐
. Do you crave for certain food? YES ☐ NO ☐
. Do you eat when you feel stressed, seeking comfort in food? YES ☐ NO ☐

What foods do you eat that you think may be a problem for your weight or for your health?
_____
_____

Describe a typical day with meals, snacks, and beverages:

BREAKFAST	
LUNCH	

DINNER	
SNACKS	

PHYSICAL ACTIVITY

Do you exercise regularly? ☐ YES ☐ NO

- If YES, what is your regimen, how many times per week, for how long?

_____

What physical activity do you enjoy or used to enjoy?

_____

_____

If you stopped that activity, what was the reason?

_____

Non exercise activities: Do you use stairs, a standing desk; do you do any yard work or house work? ☐ YES ☐ NO

MEDICAL HISTORY

1. Do you consider yourself in good health? ☐ YES ☐ NO

MEDICAL HISTORY Mark (x) all that apply.

☐ Acid Reflux Disease ☐ Alcoholism ☐ Anemia ☐ Anorexia ☐ Arthritis ☐ Asthma/Lung Problem ☐ Bleeding Disorders ☐ Bulimia ☐ Cancer ☐ Chemical Dependency ☐ Depression ☐ Diabetes (Type 1) ☐ Diabetes (Type 2)	☐ Emphysema ☐ Epilepsy ☐ Fatty Liver ☐ Gall Bladder Disease ☐ Glaucoma ☐ Goiter ☐ Gout ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol	☐ HIV Disease ☐ Irregular Menstrual Periods ☐ Impaired Fasting Glucose ☐ Kidney Disease ☐ Kidney Stones ☐ Liver Disease ☐ Migraines ☐ Miscarriage ☐ Multiple Sclerosis ☐ Osteoporosis/penia ☐ PCOS	☐ Pacemaker ☐ Pancreatitis ☐ Prediabetes ☐ Prostate Problem ☐ Psychiatric Care ☐ Sleep Apnea ☐ Stroke ☐ Suicide Attempt ☐ Thyroid Problems ☐ Tuberculosis ☐ Ulcers ☐ Other_____

SYMPTOMS Mark (x) all that apply.

GENERAL	☐ Weight Loss ☐ Chills	☐ Weight gain ☐ Sweats	☐ Fatigue ☐ Loss of Appetite	☐ Discomfort ☐ Fever
EYES	☐ Blurring ☐ Eye pain	☐ Double vision ☐ Vision Loss	☐ Irritation ☐ Intolerance of light	☐ Discharge ☐ Swelling

GASTROINTESINAL	☐ Indigestion/Heart burn ☐ Change in bowel habits	☐ Diarrhea ☐ Excessive gas	☐ Constipation ☐ Stomach pain ☐ Hemorrhoids	☐ Nausea ☐ Vomiting ☐ Blood in stool
NEUROLOGIC	☐ Temporary paralysis ☐ Seizures	☐ Tremors ☐ Loss of consciousness	☐ Numbness ☐ Tingling	☐ Dizziness ☐ Weakness ☐ Headache
RESPIRATORY	☐ Shortness of breath	☐ Cough ☐ Wheezing	☐ Coughing up blood	☐ Coughing up sputum
PSYCHIATRIC	☐ Depression ☐ Anxiety	☐ Suicidal thoughts ☐ Hallucinations	☐ Mental disturbance ☐ Memory loss	☐ Paranoia
EARS/NOSE/THROAT	☐ Sore throat ☐ Ringing/buzzing in ears	☐ Ear discharge ☐ Nosebleeds	☐ Hoarseness ☐ Difficulty swallowing	☐ Loss of hearing ☐ Earache
CARDIOVASCULAR	☐ Chest pain/pressure ☐ Irregular heart beat	☐ Swelling of ankles	☐ Loss of consciousness ☐ Varicose veins	☐ Shortness of breath
MUSCULOSKELETAL	☐ Back pain ☐ Joint pain	☐ Muscle cramps ☐ Stiffness	☐ Muscle weakness	☐ Arthritis
ENDOCRINE	☐ Cold intolerance ☐ Frequent thirst	☐ Heat intolerance	☐ Weight gain ☐ Increased hunger	☐ Weight loss ☐ Increased urination
GENITO-URNIARY (MEN ONLY)	☐ Painful urination ☐ Blood in urine	☐ Breast lump ☐ Frequent urination	☐ Poor bladder control ☐ Decreased sex drive	☐ Erection difficulties

GENITO-URNIARY (WOMEN ONLY)	☐ Vaginal discharge ☐ Painful urination ☐ Blood in urine	☐ Breast lump ☐ Frequent urination ☐ Pelvic pain	☐ Poor bladder control ☐ Decreased sex drive	☐ Irregular menstrual period ☐ Absent menstrual period
ALLERGIC/ IMMUNOLOGIC	☐ Skin conditions ☐ Hay fever	☐ HIV exposure ☐ Enlarged lymph nodes	☐ Persistent infections	
HEME/LYMPHATIC	☐ Abnormal bruising	☐ Bleeding		
SKIN	☐ Rash ☐ Itching	☐ Dryness	☐ Suspicious Wounds	

1. Other present health problems/dates of diagnosis: _____
_____

2. List all surgeries/hospital admissions with date and reason:
_____
_____

3. List your current medications. Include any vitamins and supplements:
1.) _____
2.) _____
3.) _____
4.)_____
5.)_____
6.) _____
7.) _____
8.) _____

4. Some medications can cause weight gain. Do you take medication for any of the following conditions? Note that **not** all medications for these conditions cause weight gain.
☐Depression ☐Mood Disorders ☐Seizures ☐Diabetes ☐Birth Control ☐Endometriosis
☐Beta/Alpha Blockers for Blood Pressure ☐Strong Antihistamines for Severe Allergies
☐HIV Infection ☐OTC Sleep Medication (ie Tylenol PM) ☐Steroid Hormones for

Inflammation, Arthritis ☐ None of the Above

5. Do you think you have gained weight since starting a medication? YES ☐ NO ☐
6. Date of last electrocardiogram (EKG): _____
7. Have you ever felt the need to cut down on drinking? YES ☐ NO ☐
8. Have you ever felt annoyed by criticism of drinking? YES ☐ NO ☐
9. Have you ever had guilty feelings about drinking? YES ☐ NO ☐
10. Have you ever been dependent on drugs or prescription medications? YES ☐ NO ☐
11. Have you ever been hospitalized for mental or nervous disorder? YES ☐ NO ☐
12. Have you ever consulted a therapist for any type of problem? YES ☐ NO ☐
13. Do you feel you need a psychological help now? YES ☐ NO ☐
14. Do you sleep badly? YES ☐ NO ☐
15. Do you smoke cigarettes now? YES ☐ NO ☐ QUIT: date: _____
    · If yes, how many cigarettes or packs per day? _____

FAMILY HEALTH HISTORY:

Do you have any family history of ?

Obesity YES ☐ NO ☐ Diabetes? YES ☐ NO ☐ Heart Disease? YES ☐ NO ☐

Thyroid Cancer YES ☐ NO ☐

SOCIAL HISTORY:

Do you use Alcohol? YES ☐ NO ☐

Do you use illicit drugs? YES ☐ NO ☐

Do you smoke? YES ☐ NO ☐

PEDIATRIC QUESTIONNAIRE: (if known)

1. Weight at birth: _____ lbs.
2. Pertinent pediatric health history: _____

ALLERGIES: Please list any allergies you have to foods, medicine or other substances:

_____

_____

MOOD ASSESMENT

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? YES ☐ NO ☐
2. During the past month, have you often felt little interest or pleasure in doing things? YES ☐ NO ☐

3. During the past month, have you often felt anxious?
YES☐ NO☐
4. Is your home life unpleasant?
YES☐ NO☐

SLEEP HISTORY:

In average, how many hours do you sleep in 24 hours? _____
Does your sleep schedule vary between night and day because of work? YES☐ NO☐

Sleep Apnea Risk: The Epworth Sleepiness Scale
1. I have been diagnosed with sleep apnea YES*☐ NO☐
*If YES, skip this section

Sleep medicine specialists use the Epworth Sleepiness Scale to identify the level of daytime sleepiness. Using the following scale, please rate your sleepiness on items a-h.

0 = Never Dose
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

a. Sitting and reading _____
b. Watching TV _____
c. Sitting, inactive in public (theater/meeting) _____
d. Car passenger (for 1 hour) _____
e. Lying down in the afternoon _____
f. Sitting and talking with someone _____
g. Sitting quietly after lunch (no alcohol) _____
h. Stopped for a few minutes in traffic _____

Total Score: _____
A total score of 8 or more suggest wake time sleepiness that may require a sleep evaluation to determine if you have an underlying sleep disorder. Please share this information with your health care provider. Reference: Johns MW. *A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale*. Sleep 1991; 14(6):540-5.

MOTIVATION ASSESMENT:
1. How ready are you to lose weight?
☐Not ready at all ☐Slightly ready ☐Somewhat ready ☐Ready ☐Extremely ready
2. How certain are you that you will stick with the program until to get to your goal weight?

☐Not certain at all ☐Slightly certain ☐Somewhat certain ☐Certain ☐Extremely certain

3. With all the stresses in your life, how possible will it be for you to stick to a healthier way of eating?

☐Not possible ☐Uncertain ☐somewhat possible ☐Possible ☐Extremely possible

4. Are you ready to add more physical activity to your routine (more walking, more stair climbing, etc.)?

☐Not ready at all ☐Slightly ready ☐Somewhat ready ☐Ready ☐Extremely ready

5. Are you ready to increase the number of days per week that you are physically active?

☐Not ready at all ☐Somewhat ready ☐Ready ☐Extremely ready

6. I have the support of family and friends? ☐Yes ☐No