MEDICAL WEIGHT LOSS PATIENT HISTORY

Please send these forms back in the supplied envelope **at least 1 week prior to appointment**. If you cannot get these forms into the mail so that they arrive 1 week prior, **please drop off or fax at least 3 days before your appointment, or come to your appointment 60 minutes early to complete the forms.**
FAX: 952-915-8885.

(If you forget these forms or do not fill them out completely, you will need to reschedule.)

Name: _____ Date of Birth: _____

Primary Care Provider: _____ Name of Clinic: _____

Do you have a physician referral for a consultation into our program? Yes _____ No_____

Who? _____ Address: _____ Phone:_____

WEIGHT/DIET HISTORY

Current Weight: _____ How Long at Current Weight? _____ Your goal weight? _____ At what age did you first become overweight? _____

Do you feel you are more than 100 lbs or more overweight: _____ If yes, for how long? _____

What was your lowest adult weight (age 18 or above)? _____ What was your highest weight: _____ Average weight in the Past 5 Years: _____

Have you ever had a weight loss surgery?_____ What type?_____ Where?_____

Do you have a pattern or known causes of weight gain? _____
__gradual over lifetime __postpartum __depression or other significant life event (describe below) __medication related
__other (stopped smoking, etc, describe below) __sudden (unexpected) Please explain. _____

What is the primary reason you want to lose weight?
Check all that apply as well:

__get healthier __get off medications __prevent disease __be more active __improve self worth __live longer
__feel better physically __look better __feel better psychologically __other_____

How many hours of sleep do you get on a typical night? _____

Which diet programs have you tried? _____

Check all that you tried
__Weight Watchers __Slimgenics __Jenny Craig __New Day __Medifast/Optifast/Slimfast (circle) __Zone
__Overeaters Anonomous __Nutrisystem __diabetic diet __Atkins diet __low fat/ low cholesterol diet
__other high protein/low carb diets

What has been your most successful weight loss program? How much weight did you lose? How long did you keep it off?
_____

What diet medications have you tried, if any?
__phentermine __metformin
__phen-fen __used for 3 months or more? __have had echocardiogram?
__Redux __sibutramine (Meridia)
__orlistat (alli, Xenical) __topiramate (Topamax)
__Herbal supplements- name? _____ __Other products- name? _____

What have been your **past** exercise efforts?

Check all that apply:
__personal trainer __home exercise videos __group exercise classes __health club membership (YMCA, curves, snap fitness, etc.)
__other- describe_____

What is your **current** exercise program?
Type of exercise _____
Frequency (number of days per week) _____ Duration (number of minutes per session) _____
If **not** exercising, what keeps you from exercising? _____

Current Typical Eating Patterns:

Typical Breakfast: (TIME_____) Example:_____

Typical Lunch: (TIME_____) Example:_____

Typical Dinner: (TIME_____) Example:_____

When do you snack? _____ Typical snacks? _____

Typical water intake? _____

How much caffeine use (include "energy drinks"? _____

What do you take in for other fluids and how much? _____

In one week, how many times do you eat at a fast food restaurant? _____

Or, in one week, how many times do you eat at any restaurant? _____

How many fruits/ day? _____ How many vegetables/ day (exclude potato/ corn)? _____

Have you ever done binge eating? _____

Are you an emotional eater? _____Do you wake up at night to eat? _____

Describe your family dynamics around food (as a child and currently) _____

ALLERGIES: **Medications:**_____ **reactions:** _____

other:_____**reactions:** _____

MEDICATIONS:

□ **No Home or Prescription Medcations** **or** □ **Medications as below**

Initial	**Start Date**	**Home/ Prescription Medications** (include drug name and strength)	**Route** (PO, eye, inhale, etc.)	**Dose** (mg, puffs, mls, etc.)	**Frequency** (once daily, twice daily, etc)

Initial	**Start Date**	**Over the counter/ Herbal Medications** (include drug name and strength)	**Route** (PO, eye, inhale, etc.)	**Dose** (mg, puffs, mls, etc.)	**Frequency** (once daily, twice daily, etc)

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Packs per day: ____ Number of years: _____
Have you ever smoked? ☐ Yes ☐ No If yes, packs per day: ____ Number of years: _____ If yes, when did you quit? Month _____ year _____
Other chemical use: ☐ Yes ☐ No Describe: _____
History of chemical dependency or chemical dependency treatment? ☐ Yes ☐ No Describe: _____

History of Abuse:

Have you been the victim of abuse? Yes ____ No _____ If yes: Verbal ___ Physical ____ Sexual ____
As a child? _____ Have you received counseling for this? _____
Is there any violence in your current social situation? Yes ____ No _____ If so, please explain: _____

WORK HISTORY

Are you currently working? Yes _____ No _____ If no, how long unemployed? _____

How much walking is in your job? _____
Do you consider your job to be an active one? If so, please describe. _____

On a scale of 1 to 5 (1 = least happy), how happy are you with your present job? _____ On a scale of 1 to 5 (1 = least happy), how would you rate overall satisfaction with yourself? _____

FEMALE SECTION

Do you ever involuntarily lose your urine? (Such as coughing, jumping, or laughing.) ☐ Yes ☐ No

Are your periods: ☐ Regular ☐ Irregular ☐ Not Applicable First day of LMP?_____

Are you currently pregnant or have been pregnant? _____ Are you currently breastfeeding?_____

MALE SECTION

Do you have any history of erectile dysfunction or use of any erectile dysfunction medications? _____
Do you have any congenital abnormalities of penis or any previous penile surgery? _____

MENTAL HEALTH HISTORY

Do you have a diagnosis of depression, bipolar, anxiety, schizophrenia, or personality disorder or other mental health issue? Yes ____ No ___
If yes, describe past or current problems:_____
Do you have a history of chemical dependency or treatment for chemical dependency? _____
Have you ever been treated or diagnosed with an eating disorder such as compulsive overeating, anorexia nervosa, or bulimia? _____
If yes, please_____
Do you have self harm thoughts or history of past suicide attempts? Yes _____ No _____ If yes, please describe: _____
Have you ever been under the care of a psychiatrist? Yes _____ No ____ When? _____ for what? _____
Have you ever been under the care of a counselor or therapist? Yes _____ No_____ When? _____ for what? _____

MEDICAL HISTORY

There are many common **weight related health problems**, please check all that you know or think apply to you:

__Hypertension (High blood pressure)

__Diabetes Type 2

__Metabolic Syndrome (elevated blood pressure, high triglycerides, or low HDL, abnormal blood sugars)

__High Cholesterol or abnormal cholesterol profile

__Coronary Artery Disease/ or Heart Attack(s). If so, please list any cardiac studies in the last 4 years. _____

__Obstructive Sleep Apnea (If yes, do you use a CPAP/ Bipap Machine? Yes __ No __)

__Asthma

__Gastro esophageal Reflux Disease

__Gallbladder issues or Gallstones

__Polycystic Ovarian Syndrome (PCOS) or recurrent ovarian cysts

__Menorrhea (heavy periods) or Oligomenorrhea (Irregular Periods)

__Deep vein thrombosis or Pulmonary Embolism (circle which)

__Weight bearing joint pain (which joints? _____)

__Osteoarthritis/ Degenerative Arthritis (which joints? _____)

__Low back pain

__Stress incontinence (urinary leakage)

__Pulmonary hypertension (elevated blood pressure in the **lungs**)

__Recurrent skin infections or yeast infections of skin folds

__Gout

__Fatty liver (nonalcoholic liver disease)

__pseudotumor cerebri

__Any other problem you believe is because of your weight problems? Describe _____

CARDIOVASCULAR

Do you have coronary artery disease or history of heart attack? ☐ Yes ☐ No Diagnosis: _____

Do you have Congestive Heart Failure? 1. Currently 2. Past, but not currently 3. No history

Do you have high blood pressure? ☐ Yes ☐ No How long: _____

Do you require daily medications for this? ☐ Yes ☐ No

Do you have history of cardiac arrhythmias or irregular heart beat? ☐ Yes ☐ No

Do you have high cholesterol or low HDL? ☐ Yes ☐ No

Do you take medication for high cholesterol? ☐ Yes ☐ No ☐ Unknown

Do you have any chest pain? ☐ Yes ☐ No

Do you have history of blood clots? ☐ Yes ☐ No In leg or lung?_____

Do you ever pass out or lose consciousness ☐ Yes ☐ No

Do you have heart murmur? ☐ Yes ☐ No Do you have any other heart problems? _____

Have you had any cardiac studies in the past 5 years? ☐ Yes ☐ No
If yes what and where, please explain: (Ex: Echocardiogram, stress study, angiogram) _____

CANCER

Have you ever had any kind of cancer? When? Explain: _____

Other Medical History

Please now list any **other medical problems** you have had or currently have that is not listed above: circle any that of the following or add below; **glaucoma or other eye problems**, thyroid disease, **seizure disorder**, cancer, kidney stones, Abnormal Heart Valves, heart murmurs, irregular heartbeat, or other heart problems, peripheral vascular disease, restless leg syndrome._____
Please list your **past surgical history** with dates:_____

Review of Symptoms- Please check all that apply to you

General: ___fatigue ___excessive daytime sleepiness or drowsiness ___insomnia (trouble getting to sleep, staying asleep, or early morning awakening)

Eyes: ___change of vision ___eye pain

Respiratory: ___shortness of breath at rest ___shortness of breath with activity ___snoring ___waking up secondary to snoring/ stopping breathing
Cardiac:__chest pain __fast heart rate __irregular heart rate __lightheadedness __fainting or passing out

Gastrointestinal: ___heartburn ___constipation ___diarrhea ___IBS ___lactose intolerance ___wheat intolerance ___abdominal pains
Neurologic: ___headaches (AM headaches, migraine, tension, other) ___seizures
Musculoskeletal: ___low back pain ___joint pain ___mobility problems
Skin: ___acne ___recurrent skin infections

Vascular: ___swelling of lower extremities

Genital/ urinary: ___stress incontinence ___menstrual irregularity ___heavy menses ___recurrent yeast infections

Psychological: ___excessive worry ___feelings depress ___feeling "up or elated

OTHER SYMPTOMS not mentioned- please list: _____

MEDICAL CARE PHYSICIANS

Please list any physicians you receive care from, in addition to your primary care physician (listed on page 1).Include their addresses and phone numbers. (Examples: OB/GYN, Orthopedic, etc.)

Other Physicians:

Name: _____ Clinic: _____

Physician Specialty: _____ Phone: _____

Name: _____ Clinic: _____

Physician Specialty: _____ Phone: _____

FAMILY HISTORY

Family Member	Is Person Living	Age Now or at Death	Cause of Death	Average Overweight or Obese (indicate by A, OW/ OB)	High Blood Pressure	Diabetes	Cancer (Specify Type) location	Mental Health or Drug issues	Heart Problems (Type & Age)	Stroke (age of onset)	High Cholesterol
Father											
Mother											
Sibling											
Sibling											
Sibling											
Sibling											
Fathers side Grandfather											
Fathers side Grandmother											
Mothers side Grandfather											
Mothers side Grandmother											