QUESTIONAIRE FOR INITIAL EVALUATION OF WEIGHT MANAGEMENT

Name of your referring physician: _____
Name of your primary care physician: _____
Are you self-referred? ❒Yes ❒ No (If yes, how did you find us?) _____

Name	Date of Birth	Age	Gender
Marital Status	Number of children	Occupation	Ethnicity

WHAT IS YOUR WEIGHT RELATED CONCERN? _____

WHEN DID YOU FIRST DEVELOP A WEIGHT- RELATED CONCERN? _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Type 1 diabetes ❒ Yes ❒ No
Type 2 diabetes ❒ Yes ❒ No
Heart disorder ❒ Yes ❒ No. If yes please answer the following:
- ❒ I have angina.
- ❒ I have history of coronary artery disease
- ❒ I have had a myocardial infarction (heart attack)
- ❒ I have had coronary bypass surgery; Date_____
- ❒ I have had coronary angioplasty/ stent placement, Date: _____
- Date of your last EKG_____
- Date of your last cardiac evaluation _____
- Name of your cardiologist _____

Elevated cholesterol ❒ Yes ❒ No, if yes describe_____
High Blood pressure ❒ Yes ❒ No, if yes describe_____
Underactive thyroid ❒ Yes ❒ No, if yes describe_____
Kidney disease ❒ Yes ❒ No, if yes describe_____
Sleep apnea ❒ Yes ❒ No, if yes describe_____
Fatty liver ❒ Yes ❒ No, if yes describe_____
Psychiatric disorder ❒ Yes ❒ No, if yes describe_____
Arthritis/ Joint pain ❒ Yes ❒ No, if yes describe_____
Infertility ❒ Yes ❒ No, if yes describe_____
Gout ❒ Yes ❒ No, if yes describe_____
Migraine ❒ Yes ❒ No, if yes describe_____
Heartburn ❒ Yes ❒ No, if yes describe_____
Polycystic ovaries ❒ Yes ❒ No, if yes describe_____
Other: Please describe: _____

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PREVIOUS NUTRITIONAL INSTRUCTION ❒ Yes ❒ No If yes,
When? _____ Where? _____
Are there foods that you can't or don't want to eat? ❒ Yes ❒ No
If yes please describe_____
Do you eat in response to emotional distress? ❒ Yes ❒ No
Do you eat between meals (snacking)? ❒ Yes ❒ No

WEIGHT HISTORY OVER THE PAST 6 MONTHS:
❒ Stable ❒ Lost weight _____ Lbs. ❒ Gained Weight _____ Lbs.
Do you have a weight goal in mind? Please describe _____

EXERCISE HISTORY:
Do you exercise? ❒ Yes ❒ No; If yes what kind? _____
Carido ❒ Yes ❒ No; if yes describe _____
Strength training ❒ Yes ❒ No; if yes, describe _____
Walking ❒ Yes ❒ No; if yes, describe _____

YOUR PREVIOUS ATTEMPTS AT WEIGHT REDUCTION:
How many serious weight reduction attempts have you had? _____
As there a program that appeared to work for you? _____

HAVE YOU HAD ANY BEHAVIOR MODIFICATION EDUCATION? ❒ Yes ❒ No, if yes please describe _____For how long? _____months

HAVE YOU EVER BEEN ON WEIGHT LOSS MEDICATION OR ANTIOBESITY DRUGS?
❒ Yes ❒ No; If yes which one? _____
Did you have side effects? _____

NOTE: Several anti-obesity drugs should not be used when there is a concern regarding certain conditions. Please answer the following:
Have you had a personal history of pancreatitis? ❒ Yes ❒ No, if yes please describe
_____

Do you have personal or family history of medullary cancer of thyroid or multiple endocrine neoplasia? ❒ Yes ❒ No, if yes describe_____

TIME & FINANCIAL ISSUES: Do you have problem with time or financial resources to effectively follow and manage your weight management program. Please describe_____

FOR WOMEN:
- Are you currently preparing for pregnancy? ❒ Yes ❒ No; if yes describe
_____
- If you are sexually active and you are in child bearing age, what method of birth control do you use?
_____

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SLEEP & WORK:

- On average how many hours of sleep do you get at night: ____ hours

- Do you have interrupted sleep? ❒ Yes ❒ No; if yes describe _____
- Do you have sleep apnea? ❒ Yes ❒ No; if yes describe _____
- Do you use CPAP, BiPAP ❒ Yes ❒ No; if yes describe _____
- How many hours a day do you work? ____hours. Type of work? _____

PAST MEDICAL HISTORY:

Past medical illnesses: Please explain:

_____
_____
_____

Past surgical procedures: Please explain:

_____
_____
_____

FAMILY HISTORY:

Father: _____
Mother: _____
Sister: _____
Brother: _____
Others: _____

SOCIAL HISTORY:

Alcohol ❒ Yes ❒ No; If yes describe_____
Smoking history ❒ Yes ❒ No. Years of smoking _____ Amount _____
Recreational drugs ❒ Yes ❒ No; If yes describe_____
Hobbies: _____

ALLERGIES: ❒ I have no known drug allergy.
❒ I am allergic to following drugs: _____

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PLEASE BRING THE FOLLOWING REPORTS WITH YOU:

1- **MEDICATIONS:** Complete the medication sheet. Include, name, dose and frequency of drugs you are using.
2- **MOST RECENT LABORATORY TESTS:** Attach a copy of the results
3- **MOST RECENT RADIOLOGICAL STUDIES:** Attach a copy of the results
4- **OTHER HEALTH CARE PROVIDERS:** Please attach name and contact information for all health care providers you see regularly.

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