Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications Medication Allergies

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

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

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

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

**­Weight History**

* What times in your life did you gain weight? (please circle/fill in)

Childhood Puberty Pregnancy Menopause

Job activity change Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Prior weight loss efforts and outcomes:

**Nutrition based**: please list any attempts to lose weight by changing eating habits, please include dates of attempts and outcome.

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| --- |
|  |
|  |
|  |
|  |
|  |

**Medications**: please list any medications used to aid in weight loss, include the name, strength, dates, and outcome.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**Surgery**: please list any surgeries you have had to aid in weight loss, include type of surgery, date, and outcome.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

* Nutrition:

How many meals do you eat per day? \_\_\_\_\_\_\_

How many servings of fruit/vegetables do you have per day? \_\_\_\_\_\_

How many sugar sweetened beverages do you have per day? \_\_\_\_\_

(soda, sweet tea, coffee/tea condiments, juice etc…)

What are your food triggers? (please circle/fill in)

Stress Boredom Anger Comfort Social situations

TV Other \_\_\_\_\_\_\_\_\_\_\_\_

How many times per week do you eat fast food? \_\_\_\_\_\_

Is there any other information related to your current eating habits that you would like to share?

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

* ­Physical Activity

**Exercise:**

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-exercise Activities:** (please circle/fill in)

Stairs Standing at desk House work Yard work

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any limitations to exercise/physical activities? If yes, please specify.

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

* Sleep (please circle answer if applicable)

How many hours do you sleep at night? \_\_\_\_\_\_\_

Has anyone witnessed you snoring or stop breathing while you sleep? Yes No

Do you feel tired during the day? Yes No

Do you eat more at night/bed time? Yes No

Do you experience any sleep interruptions? Yes No

Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How long does it take you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your sleep schedule/work schedule?

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



Past Medical History

**Have you been diagnosed with any of the following conditions?** (Please circle)

Prediabetes Diabetes Gestational Diabetes PCOS

Cardiovascular Disease Cancer Thyroid Disease

Dyslipidemia Sleep Apnea Depression Gout

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History

­**Have you had any of the following surgeries?** (Please circle)

Bariatric surgery Cholecystectomy Cardiovascular Interventions

Hysterectomy Cosmetic surgery

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any of the following medications? (Please circle)

Anti-depressants Atypical Antipsychotics Diabetes treatments

Glucocorticoids Hormones

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History (Please circle/fill in)

Do you use tobacco? Yes No

How much? \_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol? Yes No

How much? \_\_\_\_\_\_\_\_\_\_\_\_

Do you use illicit/street drugs? Yes No

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hobbies/activities do you enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Family history

Does anyone in your family have the following conditions:

(Please specify who has the condition)

**Obesity**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CV disease**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thyroid disease**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcoholism**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of Systems

**General:** Please circle if you have any of the following:

Fatigue Weight gain Weight loss Appetite change

**Skin:** Please circle if you have any of the following:

Acne Dryness Rash

**Respiratory:** Please circle if you have any of the following:

Snoring Shortness of breath Cough

**Cardiovascular:** Please circle if you have any of the following:

Chest pain Palpitations Passing out Swelling

Abnormal heart rhythm Trouble breathing when lying flat

**Gastrointestinal:** Please circle if you have any of the following:

Abdominal pain Bloating Constipation Diarrhea

Food intolerance Difficulty swallowing Acid reflux

**Genitourinary:** Please circle if you have any of the following:

Change in urine flow Incontinence Waking up to urinate

**Musculoskeletal:** Please circle if you have any of the following:

Upper back pain Lower back pain Joint pain Muscle pain

**Neurologic:** Please circle if you have any of the following:

Headache Dizziness Seizures Weakness Memory loss

**Psychiatric:** Please circle if you have any of the following:

Anxiety Depression Insomnia

Eating disorders Attention deficit

**Endocrine:** Please circle if you have any of the following:

Heat intolerance Cold intolerance Excessive sweating

Increased thirst Increased urination

**Gynecologic:** Please circle if you have any of the following:

Absence of menstruation Heavy menstruation Hot flashes

Infertility Loss of libido Facial hair

**Genitourinary-Male:** Please circle if you have any of the following:

Erectile dysfunction Loss of libido Low testosterone

**Program Interests**

We offer different options to best suit your needs.

Which of the following are you interested in to help with weight loss?

☐ Lifestyle Changes

☐ Medication

☐ Medical Food (Meal Replacements)