WEIGHT MANAGEMENT CONSULTATION

Patient Name: _____ Date of Birth: _____

HEIGHT (feet/inches)	**WEIGHT** (pounds)	**BLOOD PRESSURE***	**HEART RATE**

*If you do not have a BP cuff, use your last recorded vitals.

WEIGHT HISTORY (estimated)

Year	Weight	Life Event	Weight
2019		Child Obesity	
2020		High School	
2022		College Years	
2022		Lowest Weight	
2023		Highest Weight	
2024			

ADDITIONAL INFORMATION

1. Goal Weight
2. Do you use a home scale?
3. How often do you weigh yourself?
4. Have you had bariatric surgery?
5. Which procedure? ☐ N/A ☐ Gastric ByPass ☐ Gastric Sleeve ☐ LapBand Date:
6. Are you interested in learning more about bariatric/weight loss surgery?

What motivates you to seek this intervention for weight control and loss?_____

_____

SOCIAL HISTORY:

1. Do you use any tobacco? ☐ Yes ☐ No Do you vape? ☐ Yes ☐ No
   a. If yes – what? _____
   b. How often/much? _____
2. Do you drink alcohol? ☐ Yes ☐ No
   a. If yes – what kind/how much/often? _____
3. Any drug use? ☐ Yes ☐ No
   a. If yes – type/how much/often? _____
4. History of drug overdose? ☐ Yes ☐ No
   a. If yes – when? _____

FAMILY HISTORY:

Is there Obesity in the family? ☐ Yes ☐ No If yes, please list: _____

Are there any medical illnesses in your immediate family like Diabetes? ☐ Yes ☐ No			
			Who: _____
Hypertension?	Yes	No	Who: _____
Coronary Artery Disease?	Yes	No	Who: _____
Cancer?	Yes	No	Type: _____ Who: _____
Other: _____			

WEIGHT LOSS ATTEMPT HISTORY:

Please list ALL weight loss attempts, physician-supervised programs, and self-monitored diets.

Age you first started dieting: _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ACUPUNCTURE						☐Yes ☐No
ALLI						☐Yes ☐No
ATKINS						☐Yes ☐No
KETO-DIET						☐Yes ☐No
Calorie Counting						☐Yes ☐No
FEN/PHEN or REDUX						☐Yes ☐No
JENNY CRAIG						☐Yes ☐No
MERIDIA						☐Yes ☐No
METABOLIFE						☐Yes ☐No
NUTRI-SYSTEMS						☐Yes ☐No
OPTI-FAST or MEDI FAST						☐Yes ☐No
OVER THE COUNTER DIET AIDS						☐Yes ☐No
RICHARD SIMMONS						☐Yes ☐No
SOUTH BEACH DIET						☐Yes ☐No
T.O.P.S.						☐Yes ☐No
WEIGHT WATCHERS						☐Yes ☐No
XENICAL						☐Yes ☐No
Any Rx med for weight loss? Rx Name(s):						☐Yes ☐No
Other Prescription/Shots						☐Yes ☐No
Other bariatric programs? Which Surgeon?						☐Yes ☐No
Any support groups?						☐Yes ☐No

List any other physician-supervised and documented weight loss attempts:

_____

_____

FOOD INTAKE:

What specific Food Plan/Diet are you currently following, if any? _____

How many meals do you consume per day? _____

Do you skip meals? ☐Yes ☐No Number of snacks per day? _____

Do you eat breakfast? ☐Yes ☐No

How late is your dinner? _____ When is your typical bedtime? ____ Do you snack after dinner? ___

Do you snack between meals? ☐Yes ☐No

If so, what? _____

How often? _____

Is snacking a habit? ☐Yes ☐No ☐ Depression? ☐Yes ☐No
Boredom? ☐Yes ☐No ☐ Do you binge eat? ☐Yes ☐No

If so, what? _____

How often? _____

Do you have any eating-related problems or concerns? ☐Yes ☐No If yes, please explain: _____

_____

Are you willing to cook or prefer purchasing meals? _____
Do you feel deprived of any foods? ☐Yes ☐No
Do you feel restricted of any foods? ☐Yes ☐No
Any foods/beverages not tolerated? ☐Yes ☐No If so: _____
Do you have any dietary restrictions?
Vegan ☐Yes ☐No Lactose intolerant ☐Yes ☐No
Vegetarian ☐Yes ☐No Gluten-Free ☐Yes ☐No

Other? _____

How many grams of protein do you get in daily? _____ From drinks? _____ From food? _____
How much **WATER** do you drink in a 24-hour period? ☐24oz (3 cups or less) ☐32oz (4+ cups)

☐64oz (8+ cups) Other: _____

What do you drink other than water? _____How much? _____

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	Place	Food/beverage	Amount
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

PHYSICAL ACTIVITY:
Do you exercise regularly? ☐Yes ☐No Please provide additional information in the table below.

_____

Explain any physical restrictions that keep you from exercising?_____

_____

Type of Physical Activity (Walking, Yoga, Cardio,weights, Swim, etc)	Intensity (High, Med, Low)	How Often	Comments

PERSONAL MEDICAL HISTORY

Psychologic

1. Do you have any of the following? (Please check all that apply)
   a. ☐ Depression ☐ Drug Addiction ☐ Anxiety ☐ Bipolar Disease ☐ Panic Attacks ☐ Obsessive Compulsive Disorder ☐ Eating Disorder ☐ Alcoholism ☐ Obsessive ☐ Other: _____
   b. Seeking treatment? ☐ Yes ☐ No
   c. Medications? ☐ Yes ☐ No (Please list under medications)
2. Do you have a history of suicide attempt(s) or suicidal ideation? ☐ Yes ☐ No

   If so, when: _____
3. Are you currently seeing a psychologist/psychiatrist/therapist? ☐ Yes ☐ No.

Sleep Health

1. How many hours do you typically sleep per night? _____ hours
2. If you have insomnia, do you have trouble falling asleep or staying asleep? ☐ Yes ☐ No
3. Have you been told that you stop breathing when sleeping? ☐ Yes ☐ No
4. Do you have excessive daytime sleepiness? ☐ Yes ☐ No
5. Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No
6. If yes, do you use a CPAP or oral device? ☐ Yes ☐ No

Neurological Health

1. Have you ever had a seizure? ☐ Yes ☐ No
2. If your seizures are controlled with a medication, list them on the next page.
3. When was your last seizure? _____
4. Have you had a stroke before? ☐ Yes ☐ No
5. If yes, what type of stroke and what residual effects do you have? _____

   _____

Cardiovascular

1. High blood pressure ☐ Yes ☐ No
2. Do you take medication for your high blood pressure? ☐ Yes ☐ No
   If applicable, please list under medications.
3. Heart Attack?
4. Heart Bypass surgery? Yes No When? _____
5. Stents? ☐ Yes ☐ No When? _____
6. Pacemaker? ☐ Yes ☐ No When? _____

Endocrine

1. Diabetes? ☐ Yes ☐ No
2. If Yes, do you have Low Sugar Episodes? _____
3. If Yes, please write your current A1C blood test value if known? _____
4. If Yes – medication? ☐ Yes ☐ No (Please list under medications)
5. Thyroid problems? ☐ Yes ☐ No
6. Medications? ☐ Yes ☐ No (Please list under medications)

Gastrointestinal

1. Heartburn? ☐ Yes ☐ No
   If yes – how often a week? _____
2. Medications? ☐ Yes ☐ No (Please list under medications)
3. Do you get pain in your upper abdomen after eating or in the middle of the night other than heartburn? ☐ Yes ☐ No
4. Have you ever been told you have gallstones? ☐ Yes ☐ No
5. Have you ever been told you have a fatty liver? ☐ Yes ☐ No

Respiratory

1. Do you have asthma? ☐ Yes ☐ No
2. Do you have COPD/Emphysema? ☐ Yes ☐ No
   If yes – medications? ☐ Yes ☐ No (Please list under medications)
3. How far can you walk before you get short of breath? _____

Musculoskeletal

1. Do you have joint pain? ☐ Yes ☐ No
2. If yes – where? _____
3. Do you take medication for this? ☐ Yes ☐ No (Please list under medications)
4. Have you see an Orthopedic Doctor for this? ☐ Yes ☐ No
5. Have you had surgery for this? ☐ Yes ☐ No
   a. If yes – when and what? _____
6. Are you waiting for a joint replacement until you lose weight? ☐ Yes ☐ No

Any other medical history/conditions besides those listed above?

_____

_____

_____

Medications (Including Vitamins): ☐ I currently do not take any medication

Medication	Dosage	Frequency	Comments

Please attach a separate sheet of medications if applicable.

I certify that all the information that I provided on this questionnaire is true, accurate, and complete.

_____ _____

Patient/Guardian Signature Date

_____

If Legal Representative, State Relationship to Patient