Fill out this form if you are concerned about excess body weight.

NAME: ____________________ DOB: __________ DATE: _________________

WEIGHT HISTORY

Were you overweight as a child? Yes No

What do you think your baseline weight is? _____

Weight last year? __________ Maximum Adult Weight? ________ At what age? ______

How many years have you been overweight? __________

What is the most amount of weight you have ever lost in one try? __________
How? _______________

PSYCHOSOCIAL HISTORY

Who is responsible for the food in your home? _____________

During the last 3 months, have you had any episodes of excessive overeating (eating 2 meals at one time, grazing, or nibbling all day)? Yes No
Do you ever feel a loss of control over-eating? Yes No

After overeating, do you usually increase your resolve to diet and exercise? Yes No

After overeating do you take laxatives, diuretics, or vomit? Yes No n/a

Have you ever been told that you have an eating disorder? Yes No

Are you currently in any kind of psychotherapy or counseling? Yes No

Have you ever been hospitalized for mental illness or nervous breakdown? Yes No

Have you ever attempted suicide? Yes No

NUTRITION HISTORY

How many meals do you eat each day? ___________

Do you eat or crave (sweets or salty) foods? Yes No

How many days per week do you eat out? __________Is it usually fast food? Yes No

Do you snack between meals? Yes No

What do you eat and drink on a TYPICAL/NORMAL day?

Breakfast: ____________________________

Lunch: _______________________________

Dinner: ______________________________

Snacks: ______________________________

What do you drink during the day? Coffee Juice Tea Soda Protein Drinks Other: _______

If you drink alcohol, how much and how often? ____ drinks per (day, week, month)

NAME: ___________________ DOB: __________

PHYSICAL ACTIVITY HISTORY

Do you exercise? Yes No

If yes, what do you do for exercise: ____

How many minutes per day? ______ How many days per week? _____

How long have you been doing this exercise? _________ (days, weeks, months, or years)

Do you have medical or physical problems that would limit or prevent exercise? Yes No`

Describe: ____

What type of work do you do? (desk job or active) __________________

WHAT HAVE YOU TRIED FOR WEIGHT LOSS IN THE PAST?

Diet:

High Protein | Low Carb | Low Fat | Intermittent Fasting

Calorie Counting | Atkins Diet | Mayo Clinic Diet

Exercise/physical Activity:

Gym Membership | Home Gym Equipment | Exercise videos | Personal Trainer

Other:

Health Spa | Hypnosis | Acupuncture | psychological Counseling

Weight loss Surgery:

Type and date_________________

Pre-surgery weight: ____ Lowest weight: ___ How long did you maintain lowest weight? __

Weight loss medication:

Adipex/phentermine | Contrave(buproprion/naltrexone) | Qsymia(phentermine/topiramate)

Orlistat/Alli/Xenical | Saxenda/Wegovy | Other: ____________

Reason no longer taking: ____

Supervised Weight Loss Attempts:

Diet Center or dietician | Overeaters Anonymous | Weight Loss Center | Optifast

Weight Watchers | Nutri-System | Jenny Craig | Ideal Protein

New Directions | Medifast | Supervised Calorie Counting

Why do you think you are gaining weight or having difficulty losing weight?

Increased appetite | Increased cravings | over-eating | skipping meals

Unsure | Another reason: __________________________________

NAME: ___________________ DOB: __________

OTHER

Do you have any of the following?

Smoker (previous or current)   Physical inactivity   Stress   Family history overweight

chest pain   Shortness of breath   Palpitations or heart skipping a beat/fluttering

Relative with heart attack or stroke before age 60   Loud snoring

Have you ever been told that you have any of the following?			Year diagnosed
Yes	No	Diabetes or high blood sugar	
Yes	No	High cholesterol	
Yes	No	High blood pressure	
Yes	No	Heart disease or heart attack	
Yes	No	Fatty liver/liver problem	
Yes	No	Sleep apnea	
Yes	No	Osteoarthritis or joint pain	
Yes	No	Stroke or TIA	
Yes	No	Gallstones	
Yes	No	Gout	
Yes	No	Cancer- type? ____________	
Yes	No	Anxiety or depression	
Yes	No	Pancreatitis or problem with pancreas	
Yes	No	Thyroid problem	
Yes	No	Kidney stones or kidney problems	
Yes	No	seizures	
Yes	No	gastroparesis	
Yes	No	History of drug or alcohol abuse	

Please list any other providers (doctors, physician assistants, nurse practitioners, counselors, etc.) and the reason you see them

Primary care provider: ________________
Other: ______________

Have you had blood work in the past 3 months? Yes   No   Where? _______________

NAME: ___________________ DOB: __________

<u>WOMEN ONLY:</u>

Are you planning on becoming pregnant in the next year? Yes No

If not, what are you doing for prevention? _________________________

Do you have any of the following?

Yes	No	Irregular or heavy menstrual cycles
Yes	No	Increased hair growth on chin/chest
Yes	No	ovarian cysts
Yes	No	baby over 9 pounds at birth
Yes	No	History of gestational (during pregnancy) diabetes

Who is your OB-GYN? _________________ Last visit? _____________