



A PHYSICIAN-MONITORED WEIGHT LOSS PROGRAM

MEDICAL AND BIOGRAPHICAL INFORMATION

Name Age: DOB:

Address

Work Phone: Cell: Home

May We Call You at: Cell: Home: Work:

Email Address How did you hear about us?

Primary Care Physician:

Medical History - Do you have or have had in the past any of the following:

Problems in Pregnancy	Crohns Disease	Liver Problems
Heart Attack/Angina	Epilepsy	Headaches
Heart Murmurs	Arthritis	Shortness of breath
High Blood Pressure	Constipation	Bipolar depression
Diabetes	Depression/Anxiety	Fertility problems
High Cholesterol	Chronic Fatigue	Irregular periods
Irregular heart beat	PMS	Discoloration of skin
Heartburn	Cancer	Asthma
Kidney Problems	Glaucoma	Leg Edema
Snoring / Sleep apnea	Thyroid Problem	Excess body/facial hair

Please List any other medical problems

Please List any major surgeries / Injuries:

Please List any other drug allergies:

Please List any medications you are taking

Gynecologic History

Family History

Diet History

Pregnancies	Yes	No	Number	Dates
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Natural Delivery or C-Section (Please Specify):

Menstrual	Yes	No	Onset	Duration
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Are they regular?	Yes	No
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Hormone Replacement Therapy	Yes	No	What
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Birth Control Pills	Yes	No	Type:
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Last Check Up

Overweight?	Age	Health	Disease	Cause of Death
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Father	Yes	No
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Mother	Yes	No
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Brothers	Yes	No
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Sisters	Yes	No
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Has any blood relative ever had any of the following?

Glaucoma	Yes	No	Who:
Asthma	Yes	No	Who:
Epilepsy	Yes	No	Who:
High Blood Pressure	Yes	No	Who:
Kidney Disease	Yes	No	Who:
Diabetes	Yes	No	Who:
Tuberculosis	Yes	No	Who:
Psychiatric Disorder	Yes	No	Who:
Heart Disease/Stroke	Yes	No	Who:

Diet History

What is your typical meal when NOT dieting?

Weekdays

Weekends

Breakfast

AM snack

Lunch

PM snack

Dinner

Night snack

How often do you eat at restaurants?

Name some of your favorite restaurants

Name some foods you crave

Name any food allergies

What are your worst eating habits?

Do you binge eat?	Yes	No
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Do you purge?	Yes	No
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How many glasses of water do you typically drink during the day?

Is food volume (portion size) a problem?

How often do you go for seconds?

Do you generally have a grocery list when you shop?

What time of day do you do your grocery shopping?

Are you lactose-intolerant?	Yes	No
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Do you?	Yes/No	What kind?	How much?	How often?
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Drink alcohol

Drink soda

Do you?	Yes/No	What kind?	How much?	How often?
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Drink coffee/tea				
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Use sugar				
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Smoke				
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Candy/Chocolate				
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Snack foods				
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Exercise History

Do you exercise?	Yes	No	Never	Used to	Currently
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If yes:	Types of exercise				
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How often?	For how long?				
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Please list 3 exercises/activities that you like:

Yes	No	Has a doctor ever said that you have a heart condition and should only do physical activity recommended by a doctor?
Yes	No	Do you feel pain in your chest when you do physical activity?
Yes	No	In the past month, have you had chest pain when you were not doing physical activity?
Yes	No	Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes	No	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Yes	No	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart conditions?
Yes	No	Do you know of any other reason why you should not do physical activity?

Social History

- Yes No Do you feel out of control when you eat? How often could this happen?
- Yes No Do you vomit, use laxatives or exercise to compensate for overeating?
- Yes No Do you eat when stressed, angry or bored?
- Yes No Is anyone in your household overweight?
- Yes No Are you in a relationship? How long? Any Problems?
- Yes No Do you have children Ages
- Yes No Any special challenges with them?

How long do you work?

- Yes No Any stress at work?

What is the greatest source of stress in your life right now?

- Yes No In the past 3 months have you felt down, depressed or hopeless
- Yes No In the past 3 months, have you had little or no interest/pleasure in doing things?
- Yes No For men: In the past 3 months have you had more than five drinks in one day?
- Yes No For women: In the past 3 months, have you had more than four drinks in one day?
- Yes No Do you snore on most nights (more than 3 times/week)?
- Yes No Is your snoring loud (heard through a door or a wall)?
Do you occasionally doze, or fall asleep during the day when..
- Yes No You are not busy or active?
- Yes No You are driving or stopped at a light?