

Please take a moment and answer the following questions to the best of your knowledge.

Current Weight _____ Height _____ Years Overweight _____

What was your weight one year ago _____ five years ago _____

Lowest Adult Weight _____ When _____ Highest Adult Weight _____ When _____

How many weight loss programs have you been on in which you lost 10 or more pounds _____

Maximum Weight Loss _____

Have you engaged in or experienced any of the following:

Please Circle

- | | | |
|--|-----|----|
| Binge eating (large amounts of food within 2-3 hours)? | Yes | No |
| Self-induced vomiting after overeating? | Yes | No |
| Use of diuretics to remove water weight? | Yes | No |
| Use of laxatives to increase loss of weight? | Yes | No |
| Starvation-binge cycle (alternating binges & fasting)? | Yes | No |
| Fear of not being able to stop eating voluntarily? | Yes | No |

Do you exercise? _____ **Type of exercise?** _____ **How many hours a week?** _____

Please list all the medications you are using (include prescriptions and over the counter medications such as vitamins, laxatives, hormones, pain medications, sedatives, and antacids).

Medication	Frequency (daily, 3x a day, etc)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all medical diagnoses/conditions and the date or year of diagnoses/conditions.

Diagnoses/Conditions	Date/Year
_____	_____
_____	_____
_____	_____

Have you been hospitalized and/or had any operations? Please explain

Date of last chest x-ray _____ **Results** _____

Are you having any physical pain? Yes No

If yes, location _____ Type _____ Frequency _____

Pain Scale: (circle)

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Most Severe

Are you having any limitations in performing your activities of daily living? Yes No

If yes, please explain _____

Please review and circle any and all of the following that may apply to you whether you are currently experiencing or have experienced in the past.

- | | | |
|--|-----------------------|---|
| Dental/gum problems | Indigestion/Heartburn | Diabetes |
| Trouble swallowing | Ulcer disease | Thyroid problems |
| Headaches | Nausea/Vomiting | Kidney disease |
| Neck swelling/lumps | Intestinal disease | Urinary problems |
| Changes in vision/hearing | Abdominal pain | Urinary infections |
| Asthma | Black stools | Frequent urination |
| Lung disease | Blood in stools | Nighttime urination |
| Unusual shortness of breath | Liver disease | Urination urgency |
| Chronic cough | Diarrhea | Urine release with coughing
Or sneezing |
| Coughing up blood/sputum | Gall bladder disease | |
| Wheezing | Constipation | Blood in urine |
| Irregular heartbeat | Gallstones | Easy bruising & or bleeding |
| Palpitations | Milk intolerance | High cholesterol |
| Leg/ankle swelling | Egg intolerance | High triglycerides |
| Coronary/heart disease | Dizziness | Unusual hair growth/loss |
| High blood pressure | Fainting | Heat/cold intolerance |
| Blood clots | Seizures | Insomnia |
| Chest pain/Angina | Numbness/tingling | Daytime drowsiness |
| Varicose veins | Depression | Recent heart attack |
| Cramps in legs
When walking
At night | Psychiatric disorder | Recent stroke |
| Calf tenderness | Gout | Are you now or have you been
under psychiatric care? |
| Weakness, arms/legs | Joint pain/swelling | Back pain |
| | Arthritis | |

Please explain all circled answers to the above questions. If needed use the reverse of this page.

Family History

Do you or have any of your blood relatives have/had any of the following?

Obesity	Yes	No	relationship _____
Diabetes	Yes	No	relationship _____
Hypertension	Yes	No	relationship _____
Cancer	Yes	No	relationship _____
Heart Disease	Yes	No	relationship _____
Stroke	Yes	No	relationship _____
Arthritis	Yes	No	relationship _____
Other (list)	Yes	No	relationship _____

How many servings of coffee/caffeine do you use per day? _____

How many servings of alcohol do you use per week? _____

Do you use recreational drugs? _____ **what do you use?** _____

How often do you use them? _____

How do you learn best? Reading Demonstration Hands on Watching TV

Tell us anything you feel may interfere with your ability to learn: _____

How did you learn about our weight management program?

Physician (name) _____ Yellow Pages Newspaper
 Friend Internet Other (please specify) _____

Print Name _____

Signature _____ **Date** _____