MedGem® Patient Questionnaire

Valley Weight Loss

Name: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female

↳ Please indicate if you are: ☐ Pregnant ☐ Lactating ☐ Neither

Occupation: _____ **Work hours per week:** _____

Sleep duration (average amount of sleep per night): Weekdays: _____ Weekends: _____

Do you perform any exercise or purposeful physical activities:

☐ NO ☐ YES

If yes:

How many hours and minutes per week? Hours: _____ Minutes: _____

Please rate your exertion level when you perform exercise or purposeful physical activities. Your feeling should reflect your total amount of exertion and fatigue, combining all sensations physical stress, effort and fatigue. Please check the box that best represents your activity level.

☐ Very Light ☐ Light ☐ Moderate ☐ Hard ☐ Very Hard

Desired Weight Goal: _____ **Desired Weight Goal Date**: _____

Please check YES or NO to the following questions:

1) Have you had any food within the past four (4) hours?
   ☐ NO ☐ YES
2) Have you had any caffeine within the past four (4) hours?
   ☐ NO ☐ YES
3) Have you had any tobacco products within the past hour?
   ☐ NO ☐ YES
4) Have you performed strenuous exercise within the past four (4) hours?
   ☐ NO ☐ YES
5) Have you taken any medication by mouth within the past four (4) hours?
   ☐ NO ☐ YES

To be completed by clinic staff Frame Size: ☐ S ☐ M ☐ L

Height: _____ Ft _____ In Weight: _____ Absolute V02: _____ ml/min

Predicted RMR/BMR: _____ kcals/day Normative Range for RMR/BMR: _____

Tanita Printout ☐ EMR Charting ☐ Route EMR Note to Dr. Hella ☐ Invoice ☐ Reschedule ☐