Valley Weight Loss

Please bring this form and a copy of your medication list to your scheduled appointment

Name_____ Email Address_____

Date of Birth_____ Age_____ Primary Care/ Referral Physician _____

Date of last exam _____ Date Last labs/ Where: _____

Preferred Pharmacy: _____ Pharmacy City/Location: _____

Weight History

Motivation for weight loss_____

What are your personal and weight loss goals? _____

How confident are you that you can attain these goals? Very Somewhat Slightly Not

Previous diets tried in the past?

_____Amount of wt. lost? _____ Year _____

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Height _____Current weight_____ Highest weight _____ Lowest adult weight_____

High School weight_____ Weight when married _____ Period of rapid weight gain?_____

How old were you when you first noticed signs of overweight? _____

Was there a specific life event during onset of your weight gain? _____

Have you ever taken appetite suppressants or prescription medications/OTC for weight loss? Yes No

If yes, describe the medications and your experience? _____

Behavioral

How many times per week do you eat out (include, breakfast, lunch and dinner). 1-3 4-6 7-9 10 or more

What restaurants do you frequent? _____

How many times per week do you eat "fast food" 1-3 4-6 7-9 10 or more

Do you drink coffee or tea: Yes No If yes how many cups per day: _____

Do you drink soda? Yes No If yes how many oz. per day _____ What type do you drink? Diet Regular

Do you drink alcohol? Yes No What do you drink _____ Drinks per day ____ per week _____

Do you awaken hungry during the night? Yes No How many nights per week _____

Is your spouse, fiancée or partner overweight? Yes No If yes by how much _____

Do you currently engage in regular exercise or physical activity? Yes No

Explain current activity or reasons for not exercising: _____

_____

Are you a stress eater? Not at all Somewhat Moderate Extremely

Social

Occupation_____ Work Schedule (example: shift work/nights) _____
Number of children _____ Any Lifestyle Factors that may impact mealtime_____

Medical

Current Medications, Vitamins, Minerals and Supplements. Include dosages.

_____ _____

_____ _____

_____ _____

Medication or food allergies_____

Are there any medications that may have caused you to gain weight? _____

Medical History and Previous surgeries

_____

_____

_____

Please Complete the following. Circle any and all conditions that you may have when appropriate

	Yes	No		Yes	No
Heart			Neuro		
High cholesterol High blood pressure, Chest Pain			Headaches, dizziness, numbness or tingling		
Heart Murmur, Rheumatic fever			History of seizures or stroke		
Heart Attack, palpitations, edema or swelling			Endocrine		
Irregular heart rhythm, congestive heart failure			Diabetes Type1 Type 2		
Pacemaker			Elevated or low blood sugars		
Lungs			Thyroid		
Asthma, hay fever, emphysema			GU		
Shortness of breath, wheezing, cough			Kidney Disease or trouble passing urine		
Do you smoke? Packs per day_____			Males: Any prostate troubles?		
Have you ever smoked? What year did you quit?			Females: Are you pregnant?		
GI			Eyes		
Trouble with gallstones			Eye pain, blurred vision, eye redness		
Heartburn, abdominal pain, bloating, diarrhea			ENT		
constipation			Trouble with ears, nose, throat or mouth		
Musculoskeletal			Breast		
Muscle pain, joint pain, joint stiffness, loss of strength			Any troubles with breasts?		
Are you fatigued or tired			Skin		
Family history			Skin Any troubles with skin		
Cancer, Diabetes, Stroke, Thyroid, Heart disease			Allergies?		
Other _____			Unusual Hair growth?		
Psych			Comments on any of items checked yes:		
Anxiety, Depression, Trouble with sleep					
History of eating disorder.					