Evaluation of Weight Related Medical Conditions

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Name_____ **DOB** _____ **Date** _____

Referred by:_____

How is your weight affecting your life & health? _____

_____

_____

Weight Gain History

Greatest period of weight gain? ☐Childhood ☐Teens ☐Adulthood ☐Pregnancy ☐Menopause
Did you ever gain more that 20lbs in less than 3 months? Y / N If so, how long ago _____
As best you can remember, how much did you weight 1 yr. ago? ____ 5 yrs. ago? ___ 10 yrs. ago? ___
Life events associated with your weight gain: ☐Job change ☐Marriage ☐Divorce ☐Illness
☐ Medication ☐ Abuse ☐ Travel ☐ Injury ☐ Insomnia Quitting: ☐ smoking ☐ alcohol ☐ drugs
☐ Nightshift work Other_____

Previous Weight Loss Programs (check all that apply)

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Mediterranean diet ☐ Paleo diet
☐ HCG diet ☐ Dash diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss?_____
What are your greatest challenges with dieting? _____

Have you ever taken medication to lose weight? (Check all that apply)

☐ Phentermine(Adipex/Lomaira) ☐ Phen/Fen ☐Phendimetrazine(Bontril) ☐Diethylpropion
☐ Qsymia ☐ Topiramate ☐ Bupropion(Wellbutrin) ☐ Contrave ☐ Belviq ☐ Meridia
☐ Xenecal/Alli ☐ Saxenda ☐ Ozempic ☐ Wegovy ☐ Mounjaro

Other(including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

History of Bariatric Surgery? Y / N If so, type: _____
Date of surgery: _____ Surgeon: _____
Last appointment with surgeon: _____ Next appointment with surgeon: _____
Complications from surgery? _____
Last Bariatric Labs (date, concerns?): _____ Related supplements: _____
Ever Referral for Surgery? Y / N If so and didn't get, why not? _____

Eating Patterns

How many days a week do you eat: Breakfast ___? Lunch ___? Dinner ___? Snacks____?
Number of times you eat daily ____ Do you get up at night to eat? Y / N If so, how often: ____ times
Beverages: ☐ Soda ☐ Fruit juice ☐ Sweet Tea ☐ Coffee - if so what do you add?_____
Do you drink water during the day? Yes / No Number of ounces/day _____
Daily servings of: Vegetables____ Fruit____ Meat____ Dairy____
In the last 24 hours, what did you eat for (please list times also):
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Eating Triggers: (Check all that apply)

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking Reward ☐ Social events
☐ Meetings ☐ Travel ☐ Eating Out ☐ Vacation ☐ Celebrations ☐ Holidays
☐ Other _____

Food cravings: (Check all that apply)

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast Food ☐ High Fat ☐ Large Portions
☐ Other _____

Fast Foods – Number of times per week: ___ Breakfast ___ Lunch ___ Dinner
Favorite foods _____

Exercise

Current Exercise: Type _____ Duration _____ # times/week _____
Anything prevent you from exercising? _____
Exercise you like to do/ liked in past: _____
Exercise you don't like/ didn't like in past: _____
Exercise you are thinking of pursuing soon/ in future? _____

Sleep

How many hours do you sleep per night? _____ How many times do you get up during the night? ____
Do you feel rested in the morning? Yes / No Explain_____
Related symptoms: (Check all that apply)

☐ AM Headaches ☐ Daytime Naps ☐ Snoring ☐ Apnea/choking in sleep ☐ Drowsy at work
☐ Drowsy Driving ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Other _____

Mental Health

Do you feel stressed? Anxious? Depressed? Y / N Explain _____
History of Psychiatric Disorder? Y / N (Check all that apply)

☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Binge Eating Disorder ☐ Bulimia ☐ Anorexia
☐ Other _____

On related medications? Y / N Please list names/ dosing: _____
Therapy (ever have done/ currently doing)? Y / N Explain _____

What is the most important thing you can do to improve your health? Why? _____
_____

Form adapted from "Evaluation of Weight Related Medical Conditions" by Dr. Nicholas Pennings