

The Weight Shop

Weight Loss Health Questionnaire

Patient Name: _____ DOB: _____ AGE: _____

Gender: ___Male ___Female Pharmacy Preference / Location / # _____

(Please do not fill in these numbers. For office use only)

Height	Weight	BP	Pulse	RMR/VO2	BMI 703 X wt in pounds/ht in inches/ht in inches	Waist >40 inches for a male >35 inches for a female	Ideal Body Weight	Desired Weight

Please check the appropriate boxes and add notes as needed:

My issues with weight started: ___childhood ___puberty ___adult ___after pregnancy ___after a traumatic even

Family History of weight issues: ___Yes ___No If Yes, who _____

Highest Adult Weight: _____ Date: _____ Lowest Adult Weight: _____ Date: _____

Most weight lost on any program: _____ Program? _____ Weight loss sustained for: _____

Taste preferences (Please check all that apply) ___Sweet ___Salty ___Fast Food ___Comfort Foods ___
 ___Spicy _____ Other

Eating Habits (please check all that apply) ___Binge eater ___Stress ___Boredom ___Loneliness _____

Weight Loss Programs/Diets/Medications attempted in the past:

Program	Dates	Duration	Max Wt Loss	MD Supervised
Jenny Craig				
Nutri-System				
Weight Watchers				
Opti-fast/Medi-fast				
Fen/Phen Redux				
Atkins Diet				
Sugar Busters				
Other:				

Personal Medical History (Do you have or have you ever had? Check all that apply)

Cardiovascular	Yes	No	Don't Know	Genitourinary	Yes	No	Don't know
<i>Chest Pain (Angina)</i>				<i>Frequent Bladder Infections</i>			
<i>MI (Heart Attack)</i>				<i>Difficulty with Urination</i>			
<i>High Blood Pressure</i>				<i>Kidney Stones</i>			
<i>Irregular Heart Beat</i>				<i>Kidney Failure</i>			
<i>Heart Failure</i>				<i>Leakage of Urine</i>			
<i>Palpitations</i>				<i>Other:</i>			
<i>Leg /Ankle Swelling</i>				Gynecological			
<i>Varicose Veins</i>				<i>Irregular Periods</i>			
<i>Mitral Valve Prolapsed</i>				<i>Excessively Heavy Periods</i>			
<i>High Cholesterol</i>				<i>Excessively Painful Periods</i>			
<i>Pulmonary Hypertension</i>				<i>Infertility</i>			
<i>Other:</i>				<i>Excessive Body Hair or Acne</i>			
Respiratory				<i>Polycystic Ovary Disease</i>			
<i>Asthma</i>				<i>Last Mammogram:</i>			
<i>Emphysema</i>				<i>Was it normal?</i>			
<i>Chronic Cough</i>				<i>Last Pap Smear:</i>			
<i>Wheezing</i>				<i>Was it Normal?</i>			
<i>Sleep Apnea</i>				<i>Taking Hormones? BCP/HRT</i>			
<i>Shortness of Breath</i>							
<i>Other:</i>				Hematological			
Endocrine				<i>Bleeding Tendency</i>			
<i>Hypothyroidism</i>				<i>AIDS/HIV</i>			
<i>Hyperthyroidism</i>				<i>Blood Clots</i>			
<i>Diabetes</i>				<i>Pulmonary Embolism</i>			
<i>Insulin Resistance</i>				<i>Anemia</i>			
<i>Metabolic Syndrome</i>				<i>Previous Blood Transfusion</i>			
<i>Other:</i>				<i>Other:</i>			
Head and Neck				Neurological			
<i>Ringling in Ears</i>				<i>Seizures</i>			
<i>Hearing Loss</i>				<i>Epilepsy</i>			
<i>Dizziness</i>				<i>Pseudo Tumor Cerebri</i>			
<i>Cataracts</i>				<i>Weakness in Hands or Feet</i>			
<i>Migraine Headache</i>				<i>Other:</i>			
<i>Glaucoma</i>				Psychological			
<i>Other:</i>				<i>Depression</i>			
Gastrointestinal				<i>Panic Attacks</i>			
<i>Heartburn/GERD</i>				<i>Anxiety</i>			
<i>Ulcers</i>				<i>Bipolar Disease</i>			
<i>Ulcerative Colitis</i>				<i>Schizophrenia</i>			
<i>Crohns Disease</i>				<i>Other:</i>			
<i>Gallbladder Disease</i>							

Cancer history:

Have you ever been diagnosed with cancer: ___Yes ___No

When were you diagnosed with cancer: _____Date Cancer free since: _____

What treatment have you received since diagnosis: ___Chemotherapy ___Surgery ___Radiation Therapy ___Other:

Past Medical History:

Type of Surgery	Year of Surgery

Have you had weight loss surgery before like gastric bypass, gastric stapling, etc. If so give details:

Previous Hospitalizations:

Reason for Hospitalization	Date and Year	Name of Hospital

Social Profile:

Marital Status: Single Married Divorced Separated Widowed

Do you have a support person? YES NO Name, if Yes _____

Employment Status: Employed Unemployed Retired Disabled

Are you a smoker? Yes No Packs/Day: _____

Have you smoked in the past? Yes No Age started _____ Age Quit: _____

Do you consume alcohol: Yes No Drinks / Day: _____ Social Drinker: _____

Do you use recreational drugs? Yes No Type / Frequency: _____

Education: 8th grade or less High School Graduate College Graduate

Any Postgraduate Work: _____

Screening for Sleep Apnea:

Have you ever been diagnosed with Sleep Apnea? Yes No

Do you use a C- Pap: Yes No

Do you use a Bi – Pap: Yes No

Please complete the following if you have sleep apnea:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Rating	Situation	Chance of Dozing Number
0 = would never doze	Sitting and reading	
1 = slight chance of dozing	Watching TV	
2 = moderate chance of dozing	Sitting, inactive in a public place (Theater)	
3 = high chance of dozing	As a passenger in a car for an hour without a break	
	Lying down to rest in the afternoon when circumstances permit	
	Sitting and talking to someone	
	Sitting quietly after lunch without alcohol	
		Total Score:

Review of systems (Please indicate any personal history below):

CONSTITUTIONAL SYMPTOMS	YES	NO	GASTROINTESTINAL	YES	NO
<i>Fever</i>			<i>Heartburn</i>		
<i>Chills</i>					
<i>Fatigue</i>			GENITOUTINARY		
<i>Lightheadedness</i>			<i>Painful Urination</i>		
			<i>Frequent urination</i>		
EYES			<i>Blood in Urine</i>		
<i>Eye Glasses</i>			<i>Urinary Infections</i>		
<i>Eye Discharge</i>					
<i>Eye Pain</i>			MUSCULOSKELETAL		
<i>Blurred Vision</i>			<i>Muscle Cramps</i>		
			<i>Joint Swelling</i>		
EARS/MOUTH/NOSE/THROAT			<i>Joint Pain</i>		
<i>Nose Discharge</i>			<i>Back Pain</i>		
<i>Hoarseness of Voice</i>					
<i>Decreased Hearing</i>			INTEGUMENTARY (skin, breast)		
<i>Ringing in Ears</i>			<i>Rash</i>		
<i>Bleeding from Nose</i>			<i>Dry Skin</i>		
			<i>Breast Mass</i>		
CARDIOVASCULAR			<i>Nipple Discharge</i>		
<i>Chest Pain</i>					
<i>Palpitations</i>			NEUROLOGICAL		
<i>Edema</i>			<i>Dizziness</i>		
<i>Shortness of Breath</i>			<i>Headache</i>		
<i>Coronary Artery Disease</i>			<i>Strokes</i>		
RESPIRATORY			HEMATOLOGIC/LYMPHATIC		
<i>Asthma</i>			<i>Easy Bruising</i>		
<i>Cough</i>			<i>Prolonged Bleeding</i>		
<i>Spitting up blood</i>			<i>Enlarged Lymph Nodes</i>		
<i>Shortness of breath</i>			<i>Deep Vein Thrombosis</i>		
GASTROINTESTINAL			OTHERS		
<i>Change in Bowel Habit</i>					
<i>Nausea / Vomiting</i>					
<i>Rectal Bleeding</i>					
<i>Constipation</i>					
<i>Diarrhea</i>					

Please list the names of all physicians you see:

Primary Care Physician

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Cardiologist

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Psychiatrist / Psychologist

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Pulmonary / Sleep Study Specialist

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Gastroenterologist

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Other Physician

Name: _____

Address: _____

Office Tel: _____ Office Fax: _____

Research and Support System

Are you contemplating Bariatric Surgery? ____ Yes ____ No

Do you have a family member or friend that has had bariatric surgery? ____ Yes ____ NO

Describe your present life stressors: _____

Who is your support person through difficult times? _____

What are your goals expected from losing the weight? _____

What do you think is your greatest hope when you lose the weight? _____

What is your greatest fear regarding this weight program? _____

What is the motivating factor making you seek this program for weight loss? _____

Please write any other concerns you may have regarding this weight program:

Signature of Patient

Date of Signature

/ /

Please return the completed form along with a copy of your driving license and the front and back of your insurance card to:

The Weight Shop
953 Dougherty Road (Unit A)
Aiken, South Carolina 29803

Failure to fill this form completely may result in undue delay in having your information reviewed. Please take some time to complete this form to avoid delays in processing insurance approvals.