MEDICAL WEIGHT LOSS PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

WEIGHT HISTORY: What has been your heaviest weight? _____ lbs
What is the least you have ever weighed as an adult? _____ lbs When? _____

In your own words, please describe what you hope to accomplish and how you believe your life will be changed by losing weight:

_____

DIETARY HISTORY: Approximate age when you first seriously dieted: _____

Check diets, diet programs and medications you have tried in the past:

	YES	NO		YES	NO		YES	NO		YES	NO
Jenny Craig	☐	☐	MediFast	☐	☐	Belviq	☐	☐	Phentermine	☐	☐
Nutri-Systems	☐	☐	Metabolife	☐	☐	Contrave	☐	☐	Pristiq	☐	☐
Weight Watchers	☐	☐	Keto Diet	☐	☐	Fen/Phen	☐	☐	Qsymia	☐	☐
OptiFast	☐	☐	Bontril	☐	☐	Meridia	☐	☐	Tenuate	☐	☐
			Other:						Other:		

DIETARY / EATING PATTERNS:

Who does the shopping at home?

_____

Who does the cooking at home?

_____

How many meals do you eat per day?

_____

How many meals do you eat **per week** outside of the home?

_____

Do you like carbohydrates (starches and sweets) more than other foods?

_____

ACTIVITY / EXERCISE:

To what extent do you enjoy activity/exercise? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

Area/Methods Utilized: ☐ Health Club ☐ Home ☐ Outdoors ☐ Pool ☐ Walking ☐ Jogging

Sports:

	YES	NO	
Aerobic/Endurance Training?	☐	☐	
Resistance Training?	☐	☐	
Frequency per week?	☐	☐	Duration per day:
Activity/Exercise in the past?	☐	☐	What kinds of activity?

WEIGHT RELATED ILLNESSES:
Have you had, or do you have, any of the following illnesses or symptoms?

	YES	NO	
1. Heart Disease?	☐	☐	If YES: Year Diagnosed:
Do you have, or have you had:	☐	☐	
Angina?	☐	☐	
CABG (coronary artery bypass graft)?	☐	☐	
Stress test to rule out cardiac problems?	☐	☐	
M.I. (myocardial infarction)?	☐	☐	
Abnormal EKG?	☐	☐	
Palpations?	☐	☐	
	YES	NO	
2. High Cholesterol?	☐	☐	If yes, Year Diagnosed:
List Medications prescribed to resolve:			
High Triglycerides?	☐	☐	
3. High Blood Pressure?	☐	☐	If yes, Year Diagnosed:
List Medications prescribed to resolve:			
4. Diabetes?	☐	☐	If yes, Year Diagnosed:
Gestational?	☐	☐	
Neuropathy?	☐	☐	
Controlled with ☐ Diet ☐ Oral Medication:			
Last fasting blood sugar:			
5. Asthma?	☐	☐	
If Yes – Year Diagnosed:			
ER visits last 2 years:			
Hospitalizations last 2 years:			
Steroids last 2 years	☐	☐	
6. Shortness of Breath?	☐	☐	
If Yes – Can walk: _____ Blocks	Stairs: _____ Flights without being winded		
7. Trouble Sleeping?	☐	☐	
Morning headaches?	☐	☐	
Restless Sleep?	☐	☐	

Awakenings at night?	☐	☐	
Daytime drowsiness?	☐	☐	
Snoring?	☐	☐	
Observed apneas?	☐	☐	
8. Sleep Apnea Syndrome?	☐	☐	If Yes, Year Diagnosed:
Last Sleep Study:			
CPAP used?	☐	☐	
9. Heartburn/esophagitis/hiatus hernia?	☐	☐	If Yes, Year Diagnosed:
Upper GI series?	☐	☐	
Endoscopy?	☐	☐	
Medications:			Frequency of use:
10. Belching up acid or sour fluid?	☐	☐	
11. Coughing or choking at night?	☐	☐	
12.Gallbladder disease?	☐	☐	If Yes: How was it diagnosed? ☐ Ultrasound ☐ Physical Exam
13. Leakage of urine with laughing/coughing/ sneezing?	☐	☐	
If Yes: Wear pads frequently?	☐	☐	
14. Low back strain/pain/sciatica?	☐	☐	
Seen by Chiropractor?	☐	☐	
Orthopedic Surgeon?	☐	☐	
Family Doctor?	☐	☐	Medications taken:

	YES	NO	
15. Pain in Hips/Knees/Ankles/Feet?	☐	☐	
Seen by chiropractor?	☐	☐	
Orthopedic Surgeon?	☐	☐	
Family Doctor?	☐	☐	Medications taken:
16. Weight related injuries and trauma:			
17. Venous Stasis Disease?	☐	☐	
Do you have Edema?	☐	☐	
Scaly and thick skin?	☐	☐	

Leg Ulcers?	☐	☐	
18. Gout?	☐	☐	
Gouty Arthritis?	☐	☐	Medications taken:
19. History of Deep Vein thrombosis (DVT), blood clots or pulmonary embolus?	☐	☐	
Family History?	☐	☐	
20. Allergies to any medications?	☐	☐	If yes, please list medication and reaction:

Medications: *Please list below <u>all medications you currently use</u>:*

Medication	Dose and Frequency	Medication	Dose and Frequency

How would you describe your general mood and emotions?

_____

Present or history of eating disorders?		
YES	NO	
☐	☐	Anorexia (fear of weight gain leading to malnutrition and usually excessive weight loss)
☐	☐	Bulimia (overeating following by vomiting, laxative/diuretic abuse and/or excessive exercise)
☐	☐	Bing Eating Disorder (consuming a large quantity of food in a short period of time)
☐	☐	Night Eating Disorder (eating late at night/waking up in the middle of the night to eat)
If you have answered YES to any of the above:		
☐	☐	Have you been in treatment for the disorder
☐	☐	Do you believe you still have problems with the disorder?

What type of medication or treatment plans have you completed related to eating disorders?

SYSTEM REVIEW Please check all symptoms you **currently experience or have experienced in the past**. Feel free to add any additional problems or information.

1.HEAD, EYE, EAR, NOSE & THROAT: ☐ nasal discharge ☐ hay fever ☐ sinus trouble ☐ earache
☐ headache ☐ blurry vision ☐ double vision ☐ haloes around lights ☐ loss of night vision
☐ ringing in ears ☐ discharge from ear ☐ loss of hearing ☐ dizziness ☐ vertigo ☐ loss of balance
☐ sore throat ☐ lump in throat ☐ trouble swallowing ☐ pain with swallowing ☐ hoarseness
☐ ***NONE OF THE ABOVE***.

2.RESPIRATORY: ☐ cough ☐ wheezing ☐ shortness of breath ☐ use of two pillows ☐ coughing up blood
☐ out of breath with exertion ☐ wake up at night short of breath ☐ wake up at night coughing or choking
☐ asthma ☐ emphysema ☐ bronchitis ☐ ***NONE OF THE ABOVE***.

3.CARDIOVASCULAR: ☐ palpitations ☐ pounding heart ☐ skipping heartbeat ☐ pains in chest
☐ pains in neck ☐ pains in arms ☐ heart attack (history of ami) ☐ heart murmur
☐ abnormal electrocardiogram ☐ high blood pressure ☐ pain in legs ☐ cold feet ☐ blue toes
☐ ***NONE OF THE ABOVE***.

4.GASTROINTESTINAL: ☐ heartburn ☐ nausea ☐ vomiting ☐ choking on food ☐ food sticking in chest
☐ burning in stomach ☐ diarrhea ☐ constipation ☐ pain with bowel movement ☐ blood in stools
☐ hemorrhoids ☐ fissures ☐ gassiness ☐ irritable bowel syndrome ☐ colitis ☐ bowel movement frequency
☐ ***NONE OF THE ABOVE***.

5.GENITOURINARY: ☐ pain with urination ☐ changes in urinary habits ☐ small urine stream
☐ blood in urine ☐ kidney stones ☐ bladder stones ☐ kidney failure ☐ nephritis ☐ urinary tract infections
☐ frequent urination ☐ getting up at night to urinate ☐ leakage of urine with cough or sneeze
☐ ***NONE OF THE ABOVE.***

6.ENDOCRINE (GLANDULAR): ☐ low thyroid ☐ hyperthyroid ☐ goiter ☐ diabetes ☐ adrenal gland tumor
☐ frequent flushing ☐ frequent heavy sweating ☐ ***NONE OF THE ABOVE***.

7.MUSCULOSKELETAL: ☐ pain in joints ☐ swelling of joints ☐ arthritis ☐ broken bones ☐ sprains
☐ low back pain ☐ hip pain ☐ knee pain ☐ ankle pain ☐ foot pain ☐ flat feet ☐ herniated disk
☐ sciatica ☐ limited joint motion ☐ ***NONE OF THE ABOVE***.

8.NEUROLOGICAL: ☐ numbness ☐ tingling ☐ weakness of any muscles ☐ twitching of muscles ☐ fainting
☐ convulsions ☐ ***NONE OF THE ABOVE***.

9. PSYCHOLOGICAL: ☐ nervousness ☐ anxiety ☐ depression ☐ thoughts of suicide ☐ suicide attempts
☐ hospitalization for emotional problems ☐ psychiatric treatment ☐ psychological counseling
☐ memory problems ☐ mood changes ☐ ***NONE OF THE ABOVE***.

*10.*REPRODUCTIVE (**Females**): ☐ premenstrual mood swings ☐ inability to conceive
☐ hormone replacement therapy ☐ *history of ovarian cysts* ☐ *menopause* ☐ *regular Pap smears*
☐ *abnormal Pap smears* ☐ *abnormal mammogram* ☐ ***NONE OF THE ABOVE***.

The above information is true and correct to the best of my belief. I understand that the accuracy of this information is important and may affect medical outcomes.

Patient Signature_____ Patient Name_____

_____
Date

Reviewed: _____