Heritage

MEDICAL WEIGHT LOSS

at The Doctor's Inn

New Patient Questionnaire

Name: ____ Birth Date: ______________________

Present weight: ______________________ Height: ______________________ Desired weight: ______________________

Weight at 20 years of age: _______________ Weight 1 year ago: _______________ Maximum weight ever: _______________

When did you begin gaining excess weight? (Give reasons, if known): ____

____

Previous diets you have followed (give dates and results of your weight loss if you can):

____

____

Is there a particular reason you are pursuing weight loss right now? ____

Activity: Describe your usual energy level:

_____ Inactive—no regular physical activity with a sit-down job

_____ Light activity—no organized physical activity during leisure time

_____ Moderate activity—occasional activities such as weekend golf, tennis, walking or jogging, swimming, or cycling

_____ Heavy activity—consistent lifting, stair climbing, heavy construction, or regular walking, swimming, or other continuous exercise at least three times per week

_____ Vigorous activity—extensive physical exercise for at least 60 minutes per session four times per week

Medical History (check all that apply, and list any others on lines provided):

yes	no		yes	no		Other (*please list—including surgeries*):
☐	☐	diabetes	☐	☐	thyroid	______________________________
☐	☐	high blood pressure	☐	☐	reflux disease	______________________________
☐	☐	high cholesterol	☐	☐	liver disease	______________________________
☐	☐	heart problems	☐	☐	gallbladder disease	______________________________
☐	☐	congestive heart failure	☐	☐	cancer	______________________________
☐	☐	sleep apnea	☐	☐	arthritis / gout	______________________________
☐	☐	insomnia	☐	☐	osteoporosis	______________________________
☐	☐	depression / anxiety	☐	☐	menopause	______________________________
☐	☐	anorexia / bulimia	☐	☐	gastric bypass / lap band	______________________________

Social History:

What is your occupation? ____

Do you currently smoke? ________________________________ If not, do you have a history of smoking? _______________

Have you ever been addicted to any medications, drugs, or alcohol (if so, please specify)? ______________________________

Who lives at home with you? ____

Current Medications (*please list all prescription meds, over-the-counter pills, or supplements you take daily, including the dosages*):

name	dosage	# of times a day
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________

Do you have any food or medication allergies? ______________________________

Family History (please write any health problems you know for the people listed):

Mother: ______________________________

Father: ______________________________

Mother's father: ______________________________

Mother's mother: ______________________________

Father's father: ______________________________

Father's mother: ______________________________

Siblings: ______________________________

Other: ______________________________

Nutrition History*:*

Do you feel your daily diet is nutritious? ______________________________

Do you understand how to read a nutrition label? ______________________________

Do you eat breakfast on a daily basis? ______________________________

Which is your biggest meal of the day? ______________________________

Do you skip meals? ______________________________

Do you have triggers for eating? ______________________________

Do you ever eat after everyone else has gone to bed? ______________________________

What are your two most common snacks? ______________________________

How often do you eat out? ______________________________

What are your two most common places to eat out? ______________________________

How many cups of water do you drink on average in a day? ______________________________

What beverages do you drink most frequently (other than water)? ______________________________

General Questions for Over-all Review:

yes	no		yes	no		yes	no		yes	no	
◻	◻	headaches	◻	◻	cough	◻	◻	diarrhea	◻	◻	frequent urination
◻	◻	dizziness	◻	◻	snoring	◻	◻	constipation	◻	◻	nighttime urination
◻	◻	insomnia	◻	◻	chest pain	◻	◻	black or bloody stool	◻	◻	back pain
◻	◻	fatigue	◻	◻	swollen ankles	◻	◻	excess facial hair	◻	◻	difficulty walking
◻	◻	poor concentration	◻	◻	heartburn	◻	◻	infertility	◻	◻	dry skin
◻	◻	cold intolerance	◻	◻	nausea / vomiting	◻	◻	irregular periods	◻	◻	rash
◻	◻	shortness of breath	◻	◻	abdominal pain	◻	◻	incontinence	◻	◻	non-healing sores