Weight Management Assessment Form

This form is confidential. Please fill out completely.
Patient Name_____ Date: _____
Name Prefer to be called _____
Address _____ City _____ State ____ Zip Code_____
Sex _____ Date of Birth _____ Age _____ Race _____
Phone: Home_____ Cell _____ Work _____
Email: _____
Preferred Contact Method _____
May we leave a message on a home machine or voice mail? _____
Social Security Number _____ Occupation _____
Employer _____ Language Preferred _____ Ethnicity _____
Marital status _____ Spouse's Name _____ Date of Birth _____
Emergency Contact Name _____
Phone number _____ Relationship to patient _____
Who referred you to our practice? _____
Pharmacy name _____
Phone Number _____
Address_____ City _____ State _____ Zip Code _____
Primary Care Physician _____
Address _____City _____State _____ Zip Code_____

Describe the main reason for your visit today:

_____
_____
_____

Any other symptoms associated with your chief complaint?

How does your weight affect your daily life? _____

Lowest Weight: _____ When? _____

Heaviest Weight:_____ When? _____

What is your goal weight or a weight where you felt comfortable? _____

What is motivating you to lose weight? _____

What challenges do we need to overcome to reach your goal? _____

Past weight loss programs/plans: (check all that apply)

- ☐ I have never tried to lose weight
- ☐ Weight Watchers
- ☐ Jenny Craig/Nutrisystem
- ☐ South Beach/ Atkins diet
- ☐ Medically Supervised Treatment: (describe) _____

Have you ever taken Phentermine? Yes/ No If yes, did you have any adverse reactions_____

Have you taken any other medications (OTC or prescription) for weight loss? Yes/No If yes, list:

_____

Social History

(please circle yes or no)

Do you smoke? Yes / No If yes, # packs per day _____ How long? _____ Past Smoker? Yes / No

Do you use smokeless tobacco? Yes/ No If yes, how long? _____

Do you drink alcohol? Yes/ No If yes, how much and how often? _____

Caffeine Use Yes/ No If yes, please state amount and frequency. _____

Do you use recreational drugs such as Cocaine, Marijuana or Methamphetamine? Yes/No If yes, please list the drug name and frequency: _____

Do you exercise? Yes/ No If yes, please describe your exercise habits.

_____

Activity Level

- ☐ Inactive- no regular physical activity/sit down job
- ☐ Light activity- no organized physical activity during leisure time
- ☐ Moderate activity- occasionally involved in weekend activities ie golf/tennis/jogging/swimming/cycling
- ☐ Heavy Activity- consistent lifting, climbing, heavy construction or regular Participation in jogging, swimming or active sports at least three times a week
- ☐ Vigorous Activity- Participation in extensive physical exercise for at least 60 Min per session 4+ times per week

Medical History

Are you allergic to any Medication? Yes/No If yes, list the medication and reaction.

Do you take any medication? Yes/ No. If yes, please list (include herbal medication)

Medication	Dosage	Frequency

Have you been hospitalized or undergone a surgical procedure? Yes/ No If yes, please list:

Surgery/Illness	Date	Physician	Hospital

FEMALES ONLY:

Last Physical Exam: Physician _____ Date _____
Last Pap Smear: Physician_____ Date _____
Was your last pap smear Normal or Abnormal? _____
Last Menstrual period _____ Do you have regular periods? _____
Have you been through menopause? Yes /No / NA
Method of birth control _____
Have you ever been pregnant? Yes/ No If yes, # of times _____
Are you pregnant or breast feeding? Yes/ No
Date of last Mammogram _____ normal or abnormal? _____
Have you ever had a Bone Density Scan (DEXA) to check for osteoporosis? _____
If so, when?_____

MALES ONLY:

Last physical exam: Physician_____ Date _____
Date of last Prostate and Rectal exam? _____Physician_____

Dietary/ Nutrition Restrictions: (include food allergies)

MENTAL HEALTH		
Is stress a major problem for you?	Yes	No
Do you feel depressed often?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with your appetite?	Yes	No
Do you cry often?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever thought about injuring yourself?	Yes	No
Do you have difficulty sleeping?	Yes	No
Have you ever seen a counselor / Therapist?	Yes	No

If you have ever received in patient treatment for a mental health illness or for substance abuse please explain _____

Have you ever or are you experiencing any of the following? (Check all that apply)

Constitutional Symptoms
- ☐ Weight gain ____ lbs
- ☐ Fever/Chills
- ☐ Weight loss ____ lbs
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Appetite change

Eyes
- ☐ Glaucoma
- ☐ Vision loss
- ☐ Blurred/Double vision

Ear/Nose/Throat/Mouth
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Snoring
- ☐ Mouth/throat irritation
- ☐ Tooth problems

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain/Pressure
- ☐ High/Low blood pressure
- ☐ Heart Racing/Palpitations
- ☐ Heart Failure
- ☐ Heart attack
- ☐ Sweating
- ☐ Ankle swelling
- ☐ Syncope/Passing out

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Liver disease
- ☐ Difficulty Swallowing
- ☐ Heartburn

Integumentary
- ☐ Skin Rash
- ☐ Dry Skin
- ☐ Eczema

Genitourinary
- ☐ Urinary retention
- ☐ Pain with urination
- ☐ Kidney Disease
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Sexual problems
- ☐ Vaginal dryness/discharge
- ☐ Penile discharge
- ☐ Frequent UTIs
- ☐ Testicular Pain/Swelling

Neurological
- ☐ Stroke
- ☐ Insomnia
- ☐ Headache/Migraine
- ☐ Dizzy spells/Vertigo
- ☐ Seizures
- ☐ Bipolar disorder
- ☐ Depression/anxiety

☐ I have not experienced any of the symptoms above

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Blood Clot(DVTor PE)

Musculoskeletal
- ☐ Muscle Wasting
- ☐ Arthritis
- ☐ Pain
- ☐ Stiffness
- ☐ Weakness

Endocrine
- ☐ Change in Sex Drive
- ☐ Cold or Heat Intolerance
- ☐ Thyroid Problems
- ☐ Blood Sugar Problems
- ☐ Change in Body Hair
- ☐ Excessive Thirst

I/My Family has a history of: (please check all that apply)

	Me	Family	Comment		Me	Family	Comment
Anemia	☐	☐	_____	Hormone Disorders	☐	☐	_____
Breast Disease	☐	☐	_____	Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____	Kidney Stones	☐	☐	_____
Chronic Pain	☐	☐	_____	Liver Disease	☐	☐	_____
Depression/Anxiety	☐	☐	_____	Lung Disease	☐	☐	_____
Diabetes, Type1or2	☐	☐	_____	Neurological Disorder	☐	☐	_____
Diverticulosis	☐	☐	_____	Osteoporosis	☐	☐	_____
Endometriosis	☐	☐	_____	Overactive Bladder	☐	☐	_____
Erectile Dysfunction	☐	☐	_____	Obesity	☐	☐	_____
Fractures	☐	☐	_____	Psychological	☐	☐	_____
Gout	☐	☐	_____	Stroke	☐	☐	_____
Glaucoma	☐	☐	_____	Stomach ulcers	☐	☐	_____
Heart Disease	☐	☐	_____	Seizures	☐	☐	_____
High Cholesterol	☐	☐	_____	GERD/Acid Reflux	☐	☐	_____
HIV/AIDS	☐	☐	_____	Sickle Cell Anemia	☐	☐	_____
Hemorrhoids	☐	☐	_____	Sleep Disorders	☐	☐	_____
Headache	☐	☐	_____	Thyroid Disease	☐	☐	_____
Hepatitis	☐	☐	_____	Spine Injury/Surgery	☐	☐	_____
Allergies	☐	☐	_____	STDs	☐	☐	_____

Other: _____

If there is anything not listed on this form that you feel the physician should be aware of please list here:

_____

_____

☐I, the undersigned, understand that I may choose to take medication for the purposes of appetite suppression and weight loss. I have been advised of the effects and side effects this medication may produce and further advised that if adverse effects are noticed I will stop taking the medication and call the clinic ASAP. Clinic hours are Monday thru Friday 8 am until 5 pm. If an adverse reaction happens outside of clinic hours, I understand that I am to go to the nearest Emergency Room. I also understand that if I become pregnant I will stop any and all medications given to me and notify the physician.
☐I do not wish to take any medication for appetite suppression or weight loss.

I hereby swear that the above medical information is correct and accurate. I give my permission to any physician or physician corporation hired by Your Company to review my medical records. I also acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Signature Date

FORM REVIEWED BY:_____