WEIGHT LOSS CONSULTATION

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Weight: _____ Height: _____
Weight loss goal: _____
Name of Family Physician who will receive your progress reports: _____
Office Address: _____
Office Phone: _____

Review of Symptoms

Do you now or have you ever had any problems related to the following systems? Please check all that apply.

General Skin	**Pulmonary**	**Gastrointestinal**	**Genitourinary**
____No active problems	____No active problems	____No active problems	____No active problems
____Fatigue	____Choking at night	____Heartburn/acid reflux	____Urinary incontinence
____Fever	____Frequent waking	____Abdominal paid	____Blood in urine
____Chills	____Daytime drowsiness	____Constipation	____Burning on urination
____Night Sweats	____Wheezing	____Diarrhea	____Prostate problems
____Rash	____Emphysema	____Blood in stool	**Gynecological**
____Weight gain	____Snoring	____Irritable bowel	____Vaginal infections
____Weight loss	____Short of breath	____Nausea	____Irregular periods
____Skin ulcers/cellulitis	____Persistent cough	____Vomiting	Last menstrual period
____Skin fold irritations	____Asthma	____Change in appetite	_____
____Skin fold infections	____COPD		Are you pregnant _____
____ Hair loss			Current Contraception
____Dry Skin			_____
Cardiac	**Neurological**	**Musculo –Skeletal**	**Psychiatric**
____No active problems	____No active problems	____No active problems	____No active problems
____Chest pain/angina	____Dizziness	____Back/neck pain	____Depression
____Heart attack/CAD	____Migraines/headaches	____Difficulty walking	____Sexual abuse
____Swelling of ankles	____Numbness/tingling	____Exercise limitations	____Alcohol abuse
____Irregular heartbeat	____Hearing loss	____Joint pain	____Dipolar disorder
____Palpitations	____Vision Loss	____Limited mobility--- use cane, crutch, or wheelchair	____Anxiety/panic issues
____Heart murmur			____ADD/OCD
			____Drug Abuse
			____ Eating Disorder

Medical History – Please check all that apply

___Anemia	___Asthma	___Tuberculosis	___Incontinence	___H-pylori
___Bleeding disorder	___COPD	___HIV/AIDS	___Thyroid problems	___Gastritis
___Blood clots in legs/lungs	___Emphysema	___Hepatitis	___Heartburn/reflux	___Hiatal Hernia
___Stroke/TIA/Seizure	___Sleep apnea	___Kidney disease	___Diabetes	___Stomach ulcers
___Congestive heart failure	___High cholesterol	___ Rheumatic fever	___Kidney stones	___High blood pressure
___Previous heart attack	___High triglycerides	___Gout	___Cancer_____	___Arthritis
___Irregular heart beat	___Stent placed _____		___Diverticulitis	
___Stress test	___Echo	___Coronary artery disease	___Polycystic Ovarian Syndrome (PCOS)	
___Liver disease	___ Liver disease requiring protein restriction			
___Kidney disease requiring protein restriction				

Past Surgical History
(Please check all that apply and write year of surgery next to procedure)

___Gallbladder ___Hernia ___Hemorrhoids ___Heart Surgery
___C-Sections ___Breast ___Colonoscopy ___Angioplasty/Stents
___Hysterectomy ___Appendix ___Colon surgery ___Previous weight loss surgery
___Tubal Ligation ___Thyroidectomy ___Knee surgery ___Pacemaker
___Back surgery ___Joint Replacement Surgery ___Other surgery_____

_____

Complications with any surgery: _____

MEDICATIONS: Please list all daily medications including over the counter medications and vitamins, herbs or supplements

Name	Dosage	Frequency	Year Started

MEDICATION ALLERGIES: Please list any known allergies or sensitivities and the reaction you had.

Name	Reaction

OTHER ALLERGIES AND SENSITIVITIES: Please list any known allergies or sensitivities and the reaction you had.

NAME			REACTION
Latex	(yes)	(no)	
IVP Dye	(yes)	(no)	
Tape	(yes)	(no)	
Iodine	(yes)	(no)	

FAMILY HISTORY – PLEASE CHECK ALL THAT APPLY

	Diabetes	High Blood Pressure	Heart Attack	Stroke	Sleep Apnea	Cancer
Mother						
Father						
Brother						
Sister						
Grandmother						
Grandfather						

SOCIAL HISTORY – PLEASE CHECK ALL THAT APPLY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Religious preference :( ) Catholic ( ) Baptist ( ) Methodist ( ) Lutheran ( ) Jehovah Witness ( ) Atheists ( ) Other_____
Education: ( ) Grade School ( ) High School ( ) College ( ) Graduate School ( ) GED
What type of work do you do?

_____

Number of people living in your home:

_____

Smoking History: ( ) Never smoked ( ) Smoke now ( ) Used to smoke, stopped _____ packs/day for _____yrs
Chemical dependency: ( ) None ( ) Using now ( ) Used to use Substance used

_____

Alcohol history: ( ) Beer ( ) Wine ( ) Liquor How often? ( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
Exercise history: ( ) Rarely ( ) occasionally ( ) 1-2 times a week ( ) 3-4 times a week ( ) 5 times or + a week
Has a doctor or healthcare professional ever told you not to exercise? _____
Do you know of a reason why you should not exercise? _____

Food Allergies/ Sensitivities

__Cocoa __Milk Protein __Corn __Soy __Eggs __Gluten __Aspartame
__MSG __Lactose __Other:_____ ___ Vegetarian

Weight- Loss Eating Habits (Please check all that apply)

__ Eating high-fat foods __Eating too many sweets __Eating too quickly __Uncontrollable binges
__Overeating when alone __Using food as reward __Only eat once a day __ Eat out too much
__ No meal planning __ No meal packing __Purge after meals __ Use laxative or diuretics
__ Waken hungry at night __
__Overeating at social events __ Drink too much soda/ tea/ sweetened beverage __Eating in reaction to boredom

Foods you crave: _____
Foods you dislike: _____
How often do you eat out: _____ where most often: _____
Who plans meals: _____ Who Cooks: _____ Who Shops: _____

Typical Breakfast	Typical Lunch	Typical Dinner	Snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Time eaten:	Time eaten:	Time eaten:	Time eaten:
Where:	Where:	Where:	Where:
With whom:	With whom:	With whom:	

Maximum Weight (non-pregnant) _____ Year: _____ Goal Weight_____ Last time at this weight: _____
In what time frame do expect to be at your goal weight: _____

Psychosocial History:

Are you at present undergoing any major lifestyle change (marriage, divorce, job change, death of someone important to you?) If so describe: _____

What other commitments do you have that might interfere with you participating in with your weight loss and wellness program? _____

When you are under stressful situations at work or family related, do you tend to eat more? Explain: _____

_____

What benefits do you hope to gain from being in this program other than losing weight? _____

_____

Who do you feel will be supportive of your weight loss and changes in lifestyle? (Check and name your choices)

( ) Spouse ( ) Children ( ) Roommate(s) ( ) Parent ( ) Friend(s) ( ) Co- worker(s) ( ) other

_____ _____ _____ _____ _____ _____ _____

Who do you feel may NOT be supportive of your weight loss and changes in lifestyle? (Check and name your choices)

( ) Spouse ( ) Children ( ) Roommate(s) ( ) Parent ( ) Friend(s) ( ) Co- worker(s) ( ) other

_____ _____ _____ _____ _____ _____ _____

List weight loss methods you have tried, please be as specific as possible

(eg. Nutrisystem, Jenny Craig, Starvation, Medications, Spa, Hypnosis, Weight Watchers, Adkins, South Beach, HCG...)

Weight Loss Method Ex: Grapefruit Diet	**Amount of time weight loss maintained** Ex: 2 months	**Reason why you stopped treatment** Ex: interaction with meds	**Problems during treatment** Ex: dizziness

If you have already had surgery and are here for aftercare, please fill out this section

Surgery date: _____ ( ) Band ( ) Bypass ( ) Sleeve ( ) Plication

Surgeon:_____

Weight at time of surgery: _____ Lowest weight achieved _____ How many fills have you had?_____

Current diet: ( ) Clear Liquids ( ) Pureed ( ) Soft ( ) Regular

Notes:_____

_____

_____

Physician/NP: _____ Date: _____

12 Reasons

"Why I Want to Reach My Goal Weight"

Name: _____ **Date:** _____

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

9_____

10_____

11_____

12_____

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your 12 reasons list is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: “I will read the entire card whenever I am confronted with a difficult food situation.” Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.