Affinity Health
Medical Weight Loss & Wellness Center

MEDICAL WEIGHT LOSS PATIENT HISTORY FORM

DEMOGRAPHIC INFORMATION:		
Today's Date:	Date of Birth:	Gender: ☐ Male ☐ Female
Last Name:		
First Name:	Age:	
Check preferred contact number: ☐ Home ☐ Cell ☐ Work		Home Phone:
Address:		Cell Phone:
City, State, Zip:		Work Phone:
Email Address:		Fax:

Ethnic/Racial Background: ☐ African American ☐ Native American ☐ Asian ☐ Hispanic ☐ White ☐ Other_____

How did you hear about our program:

☐ Website ☐ Friend ☐ Physician ☐ Newspaper ☐ Magazine ☐ Yard Sign ☐ Radio News ☐ Mailer to home
☐ Flyer at gym ☐ Attended Dr. Brown's seminar ☐ Yellow pages ☐ Groupon ☐ Other _____

Preferred pharmacy for prescriptions: _____ Phone No. _____

Primary Care Physician: _____ Phone No. _____

Address: _____

Do you want your physician to receive updates on your progress: ☐ Yes ☐ No Fax No. _____

Other Physician/specialist: _____ Phone No. _____

Other Physician/specialist: _____ Phone No. _____

Other Physician/specialist: _____ Phone No. _____

How do you rate your health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

What is your **current height**? _____ feet _____ inches Your **current weight**? _____ pounds

FOR WOMEN:

Are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Do you have abnormal periods? ☐ Yes ☐ No

Date of Last Period? _____ Are you menopausal or perimenopausal? ☐ Yes ☐ No

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Lifetime Weight History:

At which ages were you overweight *(check all that apply)*?

☐ Under 2 years ☐ Age 2-11 ☐ Age 12-19
☐ Age 20-39 ☐ Age 40-59 ☐ Age 60 or older

How would you describe your weight gain over time?

☐ Slowly Progressive ☐ Sudden In Onset ☐ Yo-Yo

What was your greatest weight (while not pregnant)? _____ Pounds.

How many years have you been overweight? _____

Previous Weight Loss History:

What has been your lowest weight (not due to illness) after age 21, which you maintained for at least 1 year?
_____ lbs at _____ yrs old, maintained for _____ yrs.

How many times have you lost 20 lbs or more *(when you were not sick)* and then gained it back?

☐ Never ☐ Once or twice ☐ Three of four times ☐ Five times of more

What is the largest amount of weight you have ever lost on a weight program? _____

In what weight loss programs have you been enrolled in the past? ☐ None

☐ Optifast ☐ Medifast ☐ LA Weight Loss ☐ Weight Watchers ☐ Atkins
☐ Jenny Craig ☐ Slim Fast ☐ beta-HCG ☐ South Beach Diet ☐ My Weight Loss Doctor
☐ Nutri-system ☐ Weight Loss physician(name)_____ ☐ Other: _____

What weight loss programs worked for you in the past? ☐ None

☐ Optifast ☐ Medifast ☐ LA Weight Loss ☐ Weight Watchers ☐ Atkins
☐ Jenny Craig ☐ Slim Fast ☐ beta-HCG ☐ South Beach Diet ☐ My Weight Loss Doctor
☐ Nutri-system ☐ Weight Loss physician(name)_____ ☐ Other: _____

Previous & Current Weight Loss Obstacles:

What factors have precipitated weight gain for you in the past?

☐ Stress _____ ☐ Enjoyment of food ☐ Events at work ☐ Financial Constraints
☐ Depression ☐ Always hungry ☐ Traveling for work ☐ New Medications
☐ Boredom eating ☐ Love sweets ☐ Disability_____ ☐ Quit Smoking
☐ Eating late/waking up to eat ☐ Poor food choices ☐ Pregnancy

☐ Other: _____

How has your current weight acted as a barrier to you enjoying life? _____

What barriers do you see to successful weight control?

☐Cost ☐ Time commitment ☐ Social Support
☐ Chronic Illness ☐ Inability to exercise ☐ Other: _____

Weight Loss Purpose & Goals:

Why are you deciding to lose weight now? _____

What is your **dream weight**? _____ Pounds. At what weight would you be **satisfied**? _____ Pounds.

Readiness for Change:

On a scale of 1 (not ready) to 5 (very ready), how ready are you to **commit** time, energy, and resources to weight-loss?

1 2 3 4 5

On a scale of 1 (not ready) to 5 (very ready), how **ready** are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how **confident** are you that you can make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you in your ability to lose weight and keep it off?

1 2 3 4 5

Current Diet:

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten / Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

What one or two things would you like to change about your diet? _____

_____

Physical Activity Level:

What is the most physically active thing you do in an average day? _____

What, if any, regular exercises do you do? How often and for how long do you participate? _____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons. _____

_____

Dieting Medications:

Please check all medications you are using or have previously used to help with weight loss: ☐ **Never taken any**

☐ Phentermine ☐ Phendimetrazine ☐ Diethylpropion (Tenuate)

☐ Bupropion (Wellbutrin) ☐ Orlistat (Xenical/Alli) ☐ Metformin

☐ Other (Please list): _____

Any complications with weight loss meds in the past (☐ Yes ☐ No)? If so, which one and what reaction:

_____

Please check all medications that have worked to help with weight loss:

☐ Phentermine ☐ Phendimetrazine ☐ Diethylpropion (Tenuate)

☐ Bupropion (Wellbutrin) ☐ Orlistat (Xenical/Alli) ☐ Metformin

☐ Other (Please list): _____

Previous Weight Loss Surgery:

Have you ever had surgery for weight loss? ☐ Yes ☐ No If yes:

What procedure? ☐ Gastric Bypass ☐ Gastric Band ☐ Gastric Sleeve ☐ Vertical Banded Gastroplasty

When was your surgery? _____ Who was your surgeon? _____

What was your weight prior to surgery? _____What is your lowest weight after surgery? _____

Have you gained weight back since surgery? ☐ No ☐ Yes (How much _____ pounds)

Medical History:

Please check if you have any of the following conditions.

☐ Diabetes ☐ Reflux Disease ☐ High Blood Pressure ☐ Sleep apnea ☐ High cholesterol
☐ Depression ☐ Fatty Liver Disease ☐ Hip Arthritis ☐ Knee Arthritis ☐ Asthma
☐ Polycystic Ovarian Syndrome ☐ Hypothyroid (low thyroid)

General
☐ Fever/Chills ☐ Night sweats ☐ Appetite Change ☐ Fatigue ☐ Insomnia

Eyes, Ears, Nose and Throat
☐ Vision problems (except glasses) ☐ Glaucoma ☐ Ear pain/Infections ☐ Sinus Drainage
☐ Blurred vision/Double Vision ☐ Hearing loss ☐ Dental problems ☐ Chronic Allergies
☐ Nose bleeds ☐ Hoarseness ☐ Ringing in the ears

Respiratory
☐ Shortness of breath ☐ Coughing ☐ Asthma or wheezing
☐ Emphysema/COPD ☐ Snoring ☐ Daytime sleepiness
☐ Disturbed sleep ☐ History of pneumonia ☐ Sleep Apnea (I use CPAP regularly ☐ Yes ☐ No)

Cardiovascular
☐ High blood pressure ☐ Heart murmur ☐ Heart disease/heart attack
☐ Congestive heart failure (CHF) ☐ Irregular heartbeat or palpitations ☐ Chest pain or discomfort
☐ Ankle or feet swelling ☐ Heart arrhythmia ☐ Abnormal EKG
☐ Have pacemaker or defibrillator ☐ Atrial fib or Atrial flutter

Gastrointestinal
☐ Nausea/vomiting ☐ Hiatal Hernia ☐ Diarrhea ☐ Liver disease
☐ Heartburn/acid reflux ☐ Belching/burping ☐ Ulcer disease ☐ Hepatitis (type) _____
☐ Hemorrhoids ☐ Colon Polyps ☐ Rectal bleeding or blood in stools
☐ Constipation ☐ Abdominal pain ☐ Pancreatic Disease
☐ Gallbladder disease/gallstones ☐ Celiac disease ☐ Difficulty Swallowing

Genitourinary
☐ Difficulty urinating ☐ Kidney Stones ☐ Enlarged prostate ☐ Decreased Sex Drive
☐ Urinary tract infections (UTIs) ☐ Infertility ☐ Inability to empty bladder fully
☐ Abnormal menstrual periods ☐ Polycystic Ovaries ☐ Urinary incontinence (leaking urine)

Endocrine
☐ Diabetes Type I ☐ High cholesterol ☐ Low Thyroid (hypo) ☐ High Thyroid (hyperthyroid)
☐ Diabetes Type II (☐ currently on Insulin?) ☐ High triglycerides ☐ Parathyroid Disease ☐ High Calcium Levels
☐ Gestational diabetes ☐ Low Blood sugar ☐ Excessive Thirst ☐ Gout
☐ Borderline/Pre- diabetes ☐ Excessive facial/body hair

Skin and Hair
☐ Bruise easily ☐ Chronic rashes or dermatitis or eczema ☐ Slow healing
☐ Skin sores or infections ☐ Skin fold infections ☐ Changing Moles
☐ Brittle nails ☐ Thinning hair/ hair loss

Musculoskeletal

☐ Aching muscles or joints ☐ Systemic Lupus ☐ Fibromyalgia ☐ Osteoporosis
☐ Arthritis ☐ Rheumatoid Arthritis ☐ Lower back pain/disc problems

Neurologic

☐ Light headed/ dizzy ☐ Fainting ☐ Memory Loss ☐ Epilepsy/Seizure
☐ Stroke ☐ Headaches or migraines ☐ Restless Leg Syndrome ☐ Nerve pain/ neuropathy

Blood/Immunologic/Lymphatic

☐ Anemia ☐ Blood clots or bleeding disorders ☐ History of blood transfusion
☐ Cancer (list type): _____
☐ Lymph Node Enlargement/Tenderness

Other Non-weight Surgical History:

Please check or list all surgeries you have had in the past.

☐ Appendix removed ☐ Gallbladder removal ☐ Other (please list)
☐ Thyroid removed ☐ Hernia repair _____
☐ Heart Surgery ☐ Bariatric surgery _____

Psychiatric/Mood History:

☐ Depression ☐ Anxiety disorder or panic attacks ☐ Bipolar disorder
☐ Psychological or psychiatric care ☐ Binge eating ☐ Anorexia
☐ Bulimia ☐ Obsessive-compulsive disorder (OCD) ☐ Drug or Alcohol Abuse
☐ Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)
☐ History of child abuse, rape, or molestation (circle one) or other:_____
☐ Other: _____

Depression Risk Assessment: Over the last 2 weeks, how often have you been bothered by any the following problems? (circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself in some way	0	1	2	3
	Add columns:	+	+	
	Total:	_____		

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	(***Check one***): ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Stress & Sleep:

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How do you cope with stress in your daily life? _____

Have you ever practiced: ☐ Meditation ☐ Yoga ☐ Relaxation breathing ☐ Tai Chi ☐ Sequential muscle relaxation ☐Visualization

How many hours of sleep do you average per night? _____

Do you feel rested when you awake? ☐ Yes ☐ No

The following questions evaluate your risk for Obstructive Sleep Apnea, a dangerous medical condition in which people stop breathing in their sleep. If you have been tested for Sleep Apnea or know you have the condition please check one of the following boxes and skip to the next section.

☐ I have had a Sleep Study and I don't have sleep apnea. (Skip to next section).
☐ I have had a sleep study and I do have sleep apnea. (Skip to next section).
☐ I don't know if I have sleep apnea or not. If so please complete this section.

For each of the following situations please choose a score from 0 to 3 to indicate how likely it is that you would fall asleep under the described circumstances.

Score 0 - no chance of dozing
Score 1 - slight chance of dozing
Score 2 - moderate chance of dozing
Score 3 - high chance of dozing

Sitting and Reading (0-3) = _____

Watching TV (0-3) = _____

Sitting inactive in a public place (movie, etc.) (0-3) = _____

As a passenger in a car for an hour without a break (0-3) = _____

Lying down to rest in the afternoon when able (0-3) = _____

Sitting and Talking to someone (0-3) =_____

Sitting quietly after a lunch without alcohol = _____

In a car, while stopped for a few minutes in traffic (0-3) = _____

For office use only _____

Family History:

Please list the people in your household and their relationship to you:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History (Cont.):

Please check all that apply:

	Father	Mother	Sisters	Brothers	Children	Grand Mom	Grand Dad
Diabetes							
Heart Disease							
High Cholesterol							
High Triglycerides							
High Blood Pressure							
Depression/Anxiety							
Gallbladder disease							
Stroke							
Asthma							
Cancer (Type?)							
Arthritis							
Osteoporosis							

Social History:

Marital Status: ☐ Married to _____ ☐ Never Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	
If married, how long? _____ If divorced, when (date)? _____	
Living arrangements (*check all that apply*): ☐ apartment ☐ house ☐ alone ☐ with roommates ☐ with wife ☐ with husband ☐ with ex-spouse ☐ w/ significant other ☐ with mother and father ☐ with mother ☐ with father ☐ children	
Church you attend: _____ City: _____ Pastor: _____	
Occupation:	
Employer:	Work Hours:
Employer Address:	
City, State, Zip:	
Education: Please circle the highest year of school you have completed: Grade School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 13 14 15 16 Graduate School: Masters Doctorate	

Describe your close friends' body weight:

Friend #1*(check one)*: ____normal weight ____ little overweight ____ overweight ____ very overweight/ obese

Friend #2*(check one)*: ____normal weight ____ little overweight ____ overweight ____ very overweight/ obese

Friend #3*(check one)*: ____normal weight ____ little overweight ____ overweight ____ very overweight/ obese

Friend #4*(check one)*: ____normal weight ____ little overweight ____ overweight ____ very overweight/ obese

Caffeine use ☐ Yes ☐ No, if yes:

☐ Coffee (# cups a day)_____ ☐ Hot tea (# cups a day)_____ ☐ Soda (type, size & # a day)_____
☐ Cold sweet or sweeten tea (type, size & # a day)_____

The above sweeten with: ☐ None/black ☐ Sugar ☐ Stevia ☐ Splenda ☐ Sweet'N Low ☐ Equal ☐ Splenda ☐ Xylitol ☐ Saccharin ☐ Aspartame
☐ Acesulfame ☐ Sucralose ☐ Sugar alcohol ☐ Other: _____

Tobacco and Alcohol Use

Do you use tobacco products?

☐ Never have
☐ Used to but I quit (how long ago?) _____
☐ I chew tobacco (how often) _____
☐ I smoke tobacco (how often) _____

How often do you drink alcohol?

☐ Never
☐ Rarely (< 1 drink per month)
☐ Occasionally (1 to 3 drinks per month)
☐ Regularly (1 to 3 drinks per week)
☐ All the time (> 3 drinks per week) On average how many _____

Recreational drugs use Do you use drugs like marijuana, cocaine, etc? ☐ Yes ☐ No, if yes explain _____

Food & Drug Allergies:

Please list all known allergies to food or medicine:

☐ I'm NOT allergic to any food or medication
☐ I AM lactose intolerant ☐ I'm NOT lactose intolerant

Allergen	Medication/Food/Other	Reaction
Example: Penicillin	*Medication*	*Hives*
Example: Peanuts	*Food*	*Throat closes*

Medications:

Please list all prescription medications you are currently taking ☐ I do **NOT** take any prescription medication

Medication	Reason for taking	Strength	Number	How often	Prescribing physician
Example: Metoprolol	*High blood pressure*	*25mg*	*1*	*Twice a day*	*Dr. Smith*

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Please list all non-prescription medications including Vitamins, Minerals and Herbal Supplements.

Substance	Reason for taking	Strength	Number	How often	Prescribing physician
Example: Fish oil tablets	*High cholesterol*	*1000 mg*	*1*	*Once a day*	*None*

Weight History Graph:

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

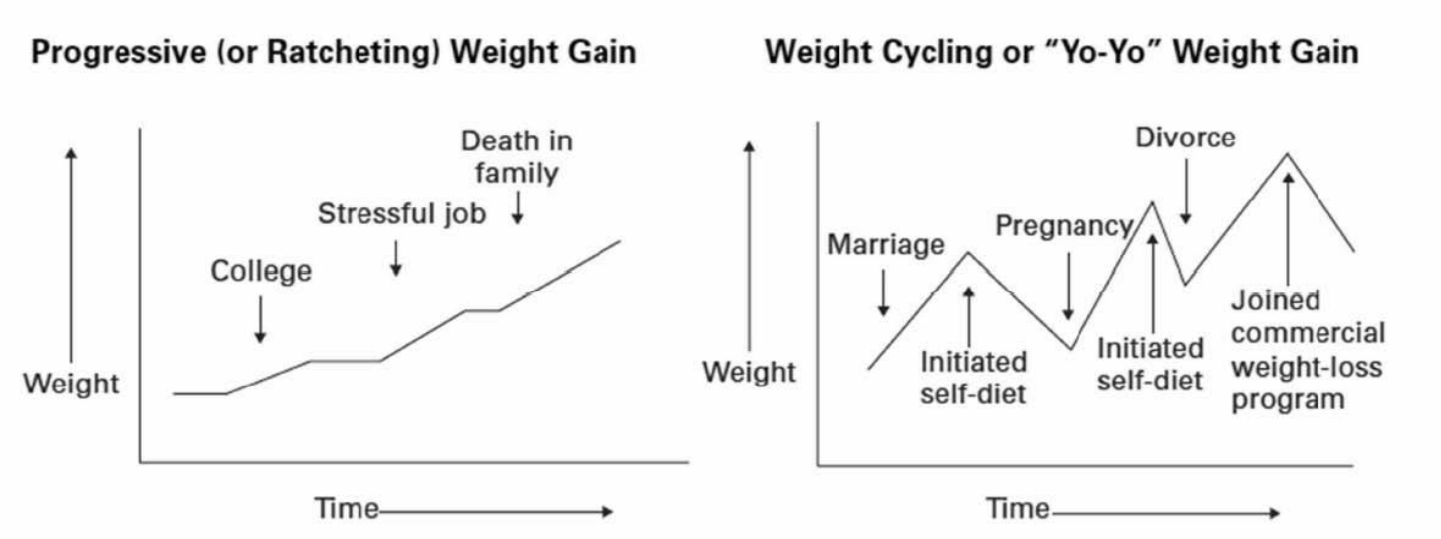

Chart your weight gain. Mark life events and diet attempts that contributed to your weight.