PATIENT HISTORY FORM

Worthy Weight Loss
Smart, sustainable weight loss

Name:_____ Date of Birth: _____
Last First Initial

☐ Male ☐ Female Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Education: Please indicate the highest year of school you have completed. ● **Your Profession:**_____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Masters Doctorate
|-----Grade School-----| |-High School-| |---- College----| |---Graduate School---|

Preferred Pharmacy for prescriptions: _____ Pharmacy's phone: _____

Referring Physician's name: _____ Referring Physician's phone: _____

Referring Physician's address:_____
Street City State Zip

Do you want your Primary Care Physician to also receive updates on your progress? ☐ Yes ☐ No

Primary Care Physician's name:_____ Primary Physician phone: _____
\
Primary Physician's Address: _____
Street City State Zip

PLEASE NOTE: Worthy Weight Loss, P.A. is a Bariatric Medicine practice.
Please be sure to become established with a Primary Care Physician for your other health care needs.

WEIGHT HISTORY:

Your Current Weight: _____Pounds What was your greatest weight (while not pregnant)? _____ Pounds.

Your Dream Weight? _____Pounds. At what weight would you be satisfied? _____ Pounds.

How would you describe your weight gain over time? ☐ Slowly Progressive ☐ Sudden In Onset ☐ Yo-Yo

At which ages were you overweight?

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

How many years have you been overweight? _____

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 or four times ☐ Five times or more

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

☐ Stress _____ ☐ Financial Constraints ☐ Poor food choices
☐ New Medications ☐ Musculoskeletal Injury ☐ Depression
☐ Quit Smoking ☐ Pregnancy ☐ Injury ☐ Other: _____

Why did you decide to lose weight now? _____

What barriers are preventing you from successful weight control?

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

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

In what weight loss programs have you been enrolled in the past?

☐ Optifast ☐ LA Weight Loss ☐ Weight Watchers ☐ Adkins
☐ Jenny Craig ☐ Personal Physician ☐ Slim Fast ☐ HCG
☐ South Beach Diet ☐ Nutri-system ☐ Other: _____

What weight loss programs worked for you in the past?

☐ Optifast ☐ LA Weight Loss ☐ Weight Watchers ☐ Adkins
☐ Jenny Craig ☐ Personal Physician ☐ Slim Fast ☐ HCG
☐ South Beach Diet ☐ Nutri-system ☐ Other: _____

Please check all medications you are using or have previously used to help with weight loss:

☐ Phentermine ☐ Phendimetrazine ☐ Diethylpropion (Tenuate)
☐ Bupropion (Wellbutrin) ☐ Orlistat (Xenical/Alli) ☐ Metformin
☐ Other (Please list): _____

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

If yes:

What procedure did you have? ☐ 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? _____

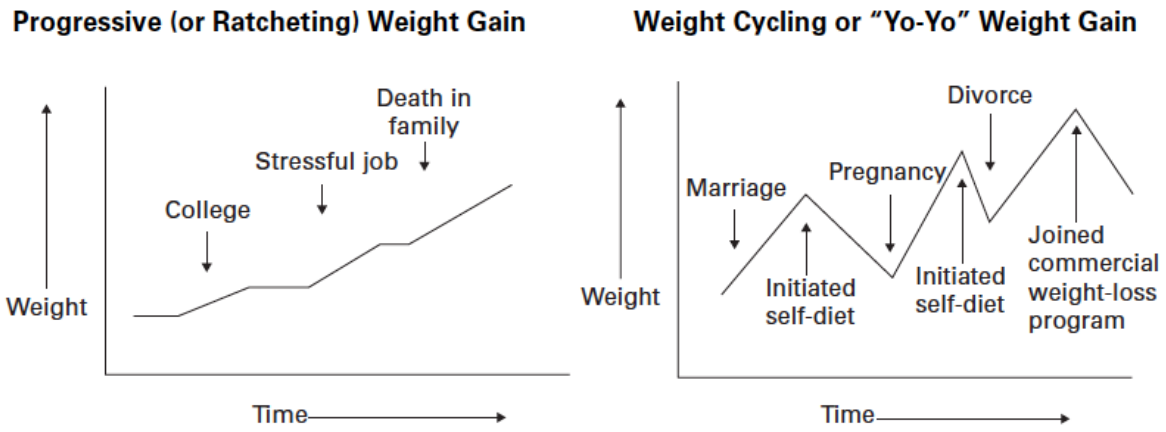
Have you gained weight back since surgery? _____ If Yes, how much weight have you gained?_____

If you have not had weight loss surgery, please check if you have any of the following conditions:

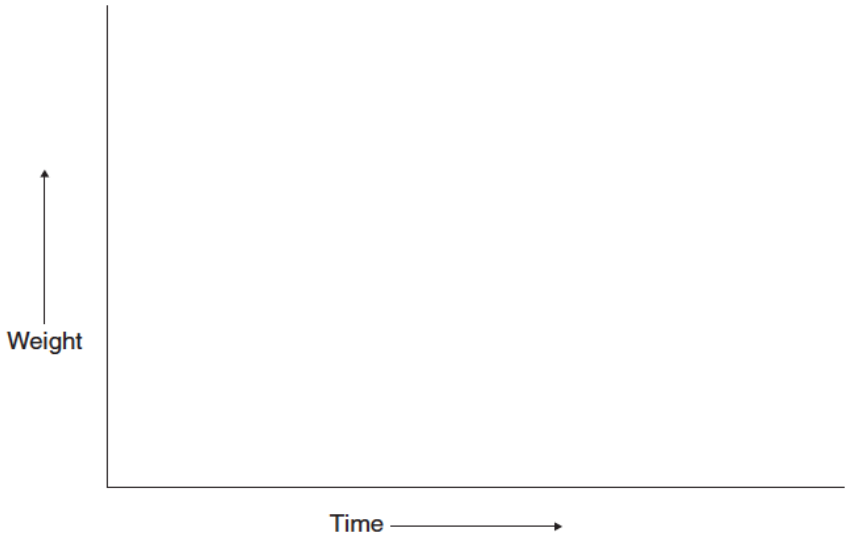
☐ Diabetes ☐ Reflux Disease ☐ High Blood Pressure ☐ Sleep apnea ☐ High cholesterol ☐ Depression
☐ Polycystic Ovarian Syndrome ☐ Fatty Liver Disease ☐ Joint Arthritis ☐ Knee Arthritis

<u>Weight History Graph</u>:

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



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.



Readiness for change:

On a scale of: (1) (not ready) ----------(5) (very ready)

How ready are you to commit time, energy, and resources to a weight-loss program now? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How confident are you that you can make lifestyle changes? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How confident are you in your ability to lose weight and keep it off? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Nutrition Information:

What one or two things would you like to change about your 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.)

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
List Foods Eaten						

Physical Activity:

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. _____

_____

REVIEW OF SYSTEMS *(check all that you currently have or are concerned about):*

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 ☐ Irregular heartbeat or palpitations ☐ Chest pain or discomfort
☐ Ankle or feet swelling ☐ Varicose veins

Gastrointestinal:

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

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 ☐ High Thyroid
☐ Diabetes Type II (☐ With Insulin?) ☐ High triglycerides ☐ Parathyroid Disease ☐ High Calcium Levels
☐ Low Blood sugar ☐ Excessive Thirst ☐ Gout ☐ Excessive facial/body hair

Hypothyroidism Screening:

Various researchers have estimated that 25% (possibly as high as 40%) of the United States population has hypothyroidism.
Please check if any of the following physical and/or emotional signs of hypothyroidism apply to you:

1. ☐ Weakness
2. ☐ Dry, coarse skin
3. ☐ Tiredness
4. ☐ Slow speech
5. ☐ Swelling of the face or eye lids
6. ☐ Body Coldness
7. ☐ Diminished sweating
8. ☐ Thick tongue
9. ☐ Coarse hair
10. ☐ Pale skin
11. ☐ Constipation
12. ☐ Persistent weight gain
13. ☐ Loss of hair
14. ☐ Labored, difficult breathing
15. ☐ Swollen feet
16. ☐ Voice hoarseness
17. ☐ Loss of appetite
18. ☐ Excessive and/or painful menstruation
19. ☐ Nervousness
20. ☐ Heart palpitation
21. ☐ Brittle nails
22. ☐ Slow movement
23. ☐ Poor memory
24. ☐ Emotional instability
25. ☐ Depression
26. ☐ Headaches

☐ **Please check here if NONE OF THE ABOVE applies to you.**

Skin and Hair:

☐ Bruise easily ☐ Chronic rashes or dermatitis or eczema ☐ Slow healing
☐ Skin sores or infections ☐ Skin fold infections ☐ Changing Moles

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/Seizures
☐ Stroke ☐ Headaches or migraines ☐ Restless Leg Syndrome

Psychiatric:

☐ Depression ☐ Bipolar disorder ☐ Anxiety disorder or panic attacks
☐ 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

Blood/Immunologic/Lymphatic:

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

OB/GYN:

☐ **I am pregnant** ☐ I'm planning to be pregnant ☐ Are you on Birth Control or Hormone Pills
☐ Do you use another form of contraception to prevent pregnancy? Please indicate _____
☐ I had a baby in the last 18 months ☐ My baby is _____(years)(months) ☐ I am breast feeding
☐ I have Polycystic Ovary Syndrome ☐ Frequent Missed Periods

Surgical History*:*

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

☐ Appendectomy ☐ Gallbladder removal ☐ Other (please list) ☐ Plastic Surgery (please list)
☐ Thyroidectomy ☐ Hernia _____ _____
☐ Heart Surgery ☐ Bariatric Surgery _____ _____

Stress Assessment:

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?_____

The following questions evaluate your risk for Obstructive Sleep Apnea, a dangerous medical condition in which people stop breathing in their sleep.

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

Do you feel rested when you wake-up? ☐ Yes ☐ No

☐ I have had a sleep study: ☐ I do have sleep apnea **OR** ☐ I don't have sleep apnea

☐ I don't know if I have sleep apnea or not.

Please use the scale from 0 to 3 to indicate **how likely it is that you would fall asleep under the described circumstances**.

(0) No chance of dozing (1) Slight chance of dozing (2) Moderate chance of dozing (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 (0-3) = ___
In a car, while stopped for a few minutes in traffic (0-3) = ___

For office use only ___

Depression Risk Assessment:

	For office use only
Are you basically satisfied with your life? ☐Yes ☐No	1. ___
Have you dropped many of your activities and interests? ☐Yes ☐No	2. ___
Do you feel that your life is empty? ☐Yes ☐No	3. ___
Do you often get bored? ☐Yes ☐No	4. ___
Are you in good spirits most of the time? ☐Yes ☐No	5. ___
Are you afraid that something bad is going to happen to you? ☐Yes ☐No	6. ___
Do you feel happy most of the time? ☐Yes ☐No	7. ___
Do you often feel helpless? ☐Yes ☐No	8. ___
Do you prefer to stay at home, rather than going out and doing new things? ☐Yes ☐No	9. ___
Do you feel you have more problems with memory than most? ☐Yes ☐No	10. ___
Do you think it is wonderful to be alive now? ☐Yes ☐No	11. ___
Do you feel pretty worthless the way you are now? ☐Yes ☐No	12. ___
Do you feel full of energy? ☐Yes ☐No	13. ___
Do you feel your situation is hopeless? ☐Yes ☐No	14. ___
Do you think that most people are better off than you are? ☐Yes ☐No	15. ___

Social History:

Do you use tobacco products?

☐ Never
☐ 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 week)
☐ Occasionally (1 to 7 drinks per week)
☐ Regularly (> 7 drinks per week)

Have you used social drugs?

☐ Never ☐ Yes
☐ I quit (When?) _____
Which drugs and how often:
_____
_____

Family History

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

_____

_____

_____

Please check all that apply to blood relatives:

	Mother	Father	Sisters	Brothers	Children
Living? (Y) or (N)					
Diabetes					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Depression/Anxiety					
Stroke					
Cancer (Type?)					
Low Thyroid					
Other:					

Please list all known allergies to food or medicine:

	Allergy Trigger	**Medication/Food/Other**	**Reaction**
Example	***Penicillin***	***Medication***	***Hives***
Example	***Peanuts***	***Food***	***Throat Closes***

Medications and Non-prescription medications (including Vitamins, Minerals and Herbal Supplements):

Please list all medications you are currently taking:

Examples	**Medication Name**	**Reason For Taking**	**Dose**	**Number**	**How often**	**Prescribing Physician**
Medicine	***Clonidine***	***High Blood Pressure***	***0.1mg***	***2 pills***	***Twice Daily***	***Dr. Jones***
Supplement	***St John's Wort***	***Depression***	***300***	***1 pill***	***Twice Daily***	***None***