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Weight Management Medical History and Assessment Forms

Name: (First)_____ (Last) _____ (MI)_____
Date of Birth: _____ Date of Visit: _____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight affect your life and health? _____
_____
_____

Weight History

When did you first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? ☐Y / ☐ N

If so, when? _____

How much did you weigh: one year ago? _____ Five years ago? _____10 years ago? _____

Life events associated with weight gain (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness
☐ Travel ☐ Injury ☐ Nightshift work ☐ Job change ☐ Quitting smoking
☐ Alcohol ☐ Drugs
☐ Medication (please list: _____)

Previous weight-loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ Intermittent Fasting ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen ☐ Wegovy
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion ☐ Plenity
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave ☐ Tirzepatide

Other (including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

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Nutritional History

How often do you eat breakfast? _____days per week at _____:_____ a.m.
Number of times you eat per day: _____What beverages do you drink? _____
Do you get up at night to eat? ☐Y / ☐ N If so, how often? ____times
List any food intolerances/restrictions: _____

How much water do you drink each day? _____oz/day

Food triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Other: _____

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food ☐ High fat ☐ Large portions
Favorite foods: _____

Medical History

Exercise type: _____
Duration: _____hours _____minutes Number of times per week: _____
Does anything limit you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____
Do you snore? ☐ Yes / ☐No Do you wear a CPAP? ☐Yes / ☐No

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gallbladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ Arthritis	☐ Polycystic Ovarian Syndrome	☐ Bipolar
☐ Glaucoma	☐ Cancer (type/s): _____		

Have you ever been diagnosed with an eating disorder? ☐Y / ☐N
If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

_____ _____ _____ _____
_____ _____ _____ _____

Allergies: _____

(Medications)_____

(Food)_____

Social History

Smoking: ☐ Never ☐ Current smoker (_____packs/day) ☐ Past smoker (quit _____years ago)

Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____drinks per day)

Prior treatment for alcoholism? ☐ Y / ☐ N

Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs:

Marijuana: ☐ Never ☐ Current user (_____times/day)

Family History

Obesity (check all that apply) ☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother

Diabetes (check all that apply) ☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Sister ☐ Brother

Other (check all that apply)

☐ High blood pressure
☐ Thyroid problems
☐ Heart Disease
☐ High cholesterol
☐ High triglycerides
☐ Stroke
☐ Anxiety
☐ Depression
☐ Bipolar disorder
☐ Alcoholism

☐ Cancer (type/s): _____

Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: ☐Regular ☐Irregular ☐Heavy ☐Normal ☐Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds ☐ Recent weight gain more than 10 pounds

☐ Acne ☐ Vision Changes ☐ Skin rash
☐ Cough ☐ Chest Pain ☐ Difficulty breathing
☐ Snoring ☐ Difficulty breathing when flat ☐ Fainting/Blacking out
☐ Palpitations ☐ Swelling ankles/extremities ☐ Abdominal pain
☐ Bloating ☐ Constipation ☐ Diarrhea
☐ Food intolerance ☐ Indigestion ☐ Nausea/vomiting
☐ Dysphagia/difficulty swallowing ☐ Increased appetite ☐ Decreased appetite
☐ Heartburn ☐ Gas and bloating ☐ Urinary frequency/urgency

☐ Slow urine flow
☐ Nighttime urination
☐ Blood in stools
☐ Back pain (upper)
☐ Back pain (lower)
☐ Joint pain
☐ Muscle aches/pain
☐ Dizziness
☐ Headaches
☐ Seizures
☐ Weakness/low energy
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Memory loss
☐ Inability to concentrate
☐ Mood changes
☐ Nervousness
☐ Loss of interest
☐ Cold intolerance
☐ Excessive sweating
☐ Hair changes
☐ Heat intolerance
☐ Blood clots
☐ Fatigue/tiredness
☐ Loss of interest in sex

(Women only)

☐ Absence of periods
☐ Hot flashes
☐ Change in bladder habits
☐ Abnormal/excessive menstruation
☐ Facial hair
☐ Difficulty getting pregnant
☐ Easy bruising
☐ Sensitive fat tissue

(Men only)

☐ Difficulty in getting erections
☐ Low testosterone

Comments: _____

_____

_____

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Name:
DOB:

Why I Want to Lose Weight…

Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to lose weight:

1._____

2._____

3._____

4._____

5._____

Describe the physical benefits you hope to get by losing weight:

_____

_____

Describe the functional benefits you hope to get by losing weight:

_____

_____

Describe the medical benefits you hope to get by losing weight:

_____

_____

Describe the psychological benefits you hope to get by losing weight:

_____

_____

Comments:

_____

_____

How I Plan to Lose Weight…

Goal setting is the “how” of weight loss. Motivators are the “why.” When setting goals, utilize the SMART technique:

SMART	Technique	Example
Specific	Who, what, where, when, how…	“I want to lose 10 pounds in two months.”
Measurable	How will you track?	What means will be used? – Weight weekly or check waist size
Attainable	Resources you have available, previous experience	“I have been able to do this before, and now I have new tools from my doctor!”
Relevant	Why this goal is important	Review your motivators
Timely	Set benchmarks and deadlines	“Focusing for two month intervals works for me.”

Please list three goals you would like to achieve during your treatment:

1._____

2._____

3._____

Eating Attitudes Test (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurate.

Part A: Complete the following Questions						
1) Birth Date- Month: Day: Year:	2) Gender: Male ☐ Female ☐					
3) Heigh- Feet: Inches:						
4) Current Weight (lbs):	5) Highest Weight (Excluding Pregnancy):					
6) Lowest Adult Weight:	7) Ideal Weight:					
Part B: Check a response for each of the following statements:	Always	Usually	Often	Some times	Rarely	Never
1. Am terrified about being overweight.	☐	☐	☐	☐	☐	☐
2. Avoid eating when I am hungry.	☐	☐	☐	☐	☐	☐
3. Find myself preoccupied with food.	☐	☐	☐	☐	☐	☐
4. Have gone on eating binges where I feel that I may not be able to stop.	☐	☐	☐	☐	☐	☐
5. Cut my food into small pieces.	☐	☐	☐	☐	☐	☐
6. Aware of the calorie content of foods that I eat.	☐	☐	☐	☐	☐	☐
7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	☐	☐	☐	☐	☐	☐
8. Feel that others would prefer if I ate more.	☐	☐	☐	☐	☐	☐
9. Vomit after I have eaten.	☐	☐	☐	☐	☐	☐
10. Feel extremely guilty after eating.	☐	☐	☐	☐	☐	☐
11. Am preoccupied with a desire to be thinner.	☐	☐	☐	☐	☐	☐
12. Think about burning up calories when I exercise.	☐	☐	☐	☐	☐	☐
13. Other people think that I am too thin.	☐	☐	☐	☐	☐	☐
14. Am preoccupied with the thought of having fat on my body.	☐	☐	☐	☐	☐	☐
15. Take longer than others to eat my meals.	☐	☐	☐	☐	☐	☐
16. Avoid foods with sugar in them.	☐	☐	☐	☐	☐	☐
17. Eat diet foods.	☐	☐	☐	☐	☐	☐
18. Feel that food controls my life.	☐	☐	☐	☐	☐	☐
19. Display self-control around food.	☐	☐	☐	☐	☐	☐
20. Feel that others pressure me to eat.	☐	☐	☐	☐	☐	☐
21. Give too much time and thought to food.	☐	☐	☐	☐	☐	☐
22. Feel uncomfortable after eating sweets.	☐	☐	☐	☐	☐	☐
23. Engage in dieting behavior.	☐	☐	☐	☐	☐	☐
24. Like my stomach to be empty.	☐	☐	☐	☐	☐	☐
25. Have the impulse to vomit after meals.	☐	☐	☐	☐	☐	☐
26. Enjoy trying new rich foods.	☐	☐	☐	☐	☐	☐
Part C: Behavioral Questions: In the past 6 months have you:	Never	Once a Month or less	2-3 times month	Once a week	2-6 times a week	One a day or more
A. Gone on eating binges where you feel that you may not be able to stop? *	☐	☐	☐	☐	☐	☐
B. Ever made yourself sick (vomited) to control your weight or shape?	☐	☐	☐	☐	☐	☐
C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	☐	☐	☐	☐
D. Exercised more than 60 minutes a day to lose or to control your weight?	☐	☐	☐	☐	☐	☐
E. Lost 20 pounds or more in the past 6 months	Yes ☐			No ☐		

*Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control

EPWORTH SLEEPINESS SCALE FORM

Instructions for completing this form:

1. Be as truthful as possible.
2. Read the situation in the first column; select your response from the second column; enter that number in the third column.
3. Total all of the entries in the third column and enter the total in the last box.
4. A score of 10 or greater indicates a possible sleep disorder.

Situation	Responses	Score
Sitting and reading	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Watching television	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting inactive in a public place, for example, a theatre or a meeting	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
As a passenger in a car for an hour without a break	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Lying down to rest in the afternoon	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting and talking to someone	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
In a car while stopped in traffic	0= would never dose 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing	
TOTAL SCORE		

Name_____ Date _____

BEDS-7

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? □Yes □ No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating? □Yes □No

Within the past 3 months…				
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?	□Never or Rarely	Sometimes	Often	Always
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?	□Never or Rarely	Sometimes	Often	Always
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?	□Never or Rarely	Sometimes	Often	Always
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?	□Never or Rarely	Sometimes	Often	Always
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?	□Never or Rarely	Sometimes	Often	Always

Diet Readiness Behavioral Questionnaire

For each question, circle the answer that best describes how you feel.

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

1	2	3	4	5
Not At All Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

3. Consider all outside factors at this time in your life (the stress you're feeling at work, your family obligations, etc). To what extent can you tolerate the effort required to stick to a diet?

1	2	3	4	5
Cannot Tolerate	Can Tolerate Somewhat	Uncertain	Can Tolerate Well	Can Tolerate Easily

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Very Unrealistic	Somewhat Unrealistic	Moderately Unrealistic	Somewhat Realistic	Very Realistic

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCOR

Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE

Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make No Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE _____

Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2	0
Yes	No

14. If you answered yes to #13, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

2	0
Yes	No

16. If you answered yes to #15 above, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Section 4 TOTAL SCOR _____

Section 5: Emotional Eating

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

18. Do you have trouble controlling your eating when you have positive feelings - do you celebrate feeling good by eating

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

19. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 5 TOTAL SCORE _____

Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Somewhat	Frequently

21. How confident are you that you can exercise regularly?

1	2	3	4	5
Not At All Confiden	Slightly Confident	Somewhat Confident	Highly Confident	Completely Confident

22. When you think about exercise, do you develop a positive or negative picture in your mind?

1	2	3	4	5
Completely Negative	Somewhat Negative	Neutral	Somewhat Positive	Completely Positive

23. How certain are you that you can work regular exercise into your daily schedule?

1	2	3	4	5
Not At All Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCOR _____