Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

Patient Name:_____ DOB:_____

Body Weight: _____ **Height:**_____

BMI: _____ % Body Fat _____ Ideal Body Weight: _____
Calculated by WMC

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

What has triggered your weight gain? _____

_____

_____

What has been an obstacle to your weight loss in the past? _____

_____

_____

What is your goal weight? _____

DIETARY HISTORY

Approximate age when you first seriously dieted:

Check the diets and diet programs you have tried:

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Jenny Craig					
Nutri-System					
Weight Watchers					
OptiFast					
MediFast					
Fen/Phen/Redux					
Meridia					
Xenical					
T.O.P.S.					
Overeaters Anonymous					

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Patient Name:_____ DOB:_____

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Acupuncture					
Metabolife					
Herbalife					
Atkins Diet					
South Beach Diet					

List any physician-supervised
and documented weight loss attempt: _____

List any other diets and/or weight
loss methods you've tried: _____

FOOD PREFERENCES

List your 10 favorite foods (imagine all are equal in calories!)

1._____ **6.**_____

2._____ **7.**_____

3._____ **8.**_____

4._____ **9.**_____

5._____ **10.**_____

24 HOUR FOOD RECALL

List all foods and beverages you eat in one day with the approximate time. Try to give specific amounts of food eaten and tell how the food was prepared (example-1/2 cup baked potato with 1 tsp. butter).

Breakfast	Time	Lunch	Time	Dinner	Time
Snack		**Snack**		**Snack**	

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WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease ❑ Yes ❑ No

If Yes: Year Diagnosed _____

Office Use: ❑ Cardiology Consult

Do you have, or have you had:

❑ Angina
❑ Heart Attack
❑ Stress test to rule out cardiac problems
❑ Congestive Heart Failure
❑ Abnormal EKG
❑ Palpitations

2. High Cholesterol ❑ Yes ❑ No High Triglycerides ❑ Yes ❑ No

If Yes: Year Diagnosed _____

List medications _____

3. High Blood Pressure ❑ Yes ❑ No

If Yes: Year Diagnosed _____

List medications _____

4. Diabetes ❑ Yes ❑ No

If Yes: Year Diagnosed _____

Gestational: ❑ Yes ❑ No

Neuropathy: ❑ Yes ❑ No

Controlled with: ❑ Diet

❑ Oral medication (list)_____

Last fasting blood sugar: _____

5. For females only, do you have polycystic ovarian syndrome? ❑ Yes ❑ No

6. Asthma ❑ Yes ❑ No

Office Use: ❑ Pulmonary Consult

If Yes: Year Diagnosed _____

ER visits last 2 years? ❑Yes ❑ No

Hospitalizations last 2 years? ❑Yes ❑ No

Steroids last 2 years? ❑ Yes ❑ No

7. Shortness of Breath ❑ Yes ❑ No

If Yes: Can walk: _____ (How far?)

Stairs: _____ (How many?)

8. Trouble Sleeping? ❑ Yes ❑ No

Office Use: ❑ Sleep Study Ordered

Morning headaches ❑ Yes ❑ No

Daytime drowsiness ❑ Yes ❑ No

Restless sleep ❑ Yes ❑ No

Snoring ❑ Yes ❑ No

Awakenings at night ❑ Yes ❑ No

Observed apneas ❑ Yes ❑ No

9. Sleep Apnea Syndrome ❑ Yes ❑ No

If Yes: Year Diagnosed: _____

Last sleep study: _____ month/year

CPAP used: ❑ Yes ❑ No

10. Heartburn/esophagitis/hiatus hernia? ❑ Yes ❑ No

If Yes: Year Diagnosed: _____

Upper GI series? ❑ Yes ❑ No

Endoscopy? ❑ Yes ❑ No

Medications: _____

Frequency of use: _____

11. Belching up acid or sour fluid? ❑ Yes ❑ No

12. Coughing or choking at night? ❑ Yes ❑ No

13. Gallbladder disease? ❑ Yes ❑ No

If Yes, how was it diagnosed? ❑ Ultrasound ❑ Physical Exam

Office Use: ❑ UGI/Endoscopy

14. Leakage of urine with laughing/coughing/sneezing? ❑ Yes ❑ No

If Yes, wear pads frequently? ❑ Yes ❑ No

Office Use: ❑ Incontinence Consult

15. Low back train/pain/sciatica? ❑ Yes ❑ No

Orthopedic Surgeon? ❑ Yes ❑ No

Seen by family doctor? ❑ Yes ❑ No

Medications taken _____

16. Pain in hips/knees/ankles/feet? ❑ Yes ❑ No

If yes, seen by Chiropractor? ❑ Yes ❑ No

Orthopedic Surgeon? ❑ Yes ❑ No

Seen by family doctor? ❑ Yes ❑ No

Medications taken _____

17. Do you have arthritis? ❑ Yes ❑ No

18. Weight related injuries and trauma: _____

_____

19. Do you have Venous Stasis Disease? ❑ Yes ❑ No

If yes, do you have lower leg swelling? ❑ Yes ❑ No

Scaly & thick skin? ❑ Yes ❑ No

Leg ulcers? ❑ Yes ❑ No

20. Do you have gout? ❑ Yes ❑ No

If yes, gouty arthritis? ❑ Yes ❑ No

Medications taken _____

21. Bra size (females only);

Skin depressions from bra straps? ❑ Yes ❑ No

Do you have shoulder pain: ❑ Yes ❑ No

Patient Name:_____ DOB:_____

22. Behavioral health

Are you on any anti-depressant medication?	❑ Yes	❑ No
Were you hospitalized for depression?	❑ Yes	❑ No
Do you have any other behavioral health issues?	❑ Yes	❑ No explain _____

23. Coping with weight management

Do you feel sad more often than usual?	❑ Yes	❑ No
Do you find yourself getting irritated or angry about little things?	❑ Yes	❑ No
Are you getting less enjoyment out of life activities than you would like?	❑ Yes	❑ No
Do you often feel tired?	❑ Yes	❑ No
Do you have trouble concentrating?	❑ Yes	❑ No
Do you ever feel worthless, like life isn't worth living?	❑ Yes	❑ No
Do you believe you are depressed?	❑ Yes	❑ No
Are you under emotional or personal stress right now?	❑ Yes	❑ No
Are you interested in meeting with our social worker to learn new strategies to cope with your weight management stressors?	❑ Yes	❑ No

PAST MEDICAL HISTORY

Please identify which of the following <u>childhood illnesses</u> you have experienced:

❑ Measles	❑ Mumps	❑ Chickenpox	❑ Obesity
❑ Rheumatic fever	❑ Heart murmur	❑ Asthma	❑ Tonsillectomy

Female Patients:

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications: _____

Pregnancy #1 Year_____Weight at start _____ at delivery _____

Pregnancy #2 Year_____Weight at start _____ at delivery _____

Pregnancy #3 Year_____Weight at start _____ at delivery _____

Pregnancy #4 Year_____Weight at start _____ at delivery _____

Do you presently use:

Birth control pills ❑ Yes ❑ No List type: _____

Estrogens ❑ Yes ❑ No List type: _____

Other Contraceptive method: _____

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Serious Illnesses:

Have you had:

❑ Hepatitis ❑ Blood Transfusion ❑ AIDS/HIV Exposure ❑ Cancer

❑ Colitis ❑ Kidney Disease ❑ Bleeding Abnormality type_____

❑ Thryroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood not listed previously.

Major Illness Date Treatment

_____

_____

_____

_____

Major Surgery Date

_____

_____

_____

_____

Allergies:

Allergies to any medications? ❑ Yes ❑ No If Yes, please list medication and reaction:

_____

_____

_____

Allergic to: **Surgical tape?** ❑ Yes ❑ No **Latex?** ❑ Yes ❑ No **Iodine?** ❑ Yes ❑ No

Other Allergies: _____

_____

Medications/Vitamins:

Medication	**Dose and Frequency**

Do you use tobacco? ❑ Yes ❑ No

Are you willing to quit? ❑ Yes ❑ No

Do you use alcohol? ❑ Yes ❑ No Frequency: _____

Office Use: ❑ Tobacco Cessation Consult

Patient Name:_____ DOB:_____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- ❑ Obesity
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ High Blood Cholesterol
- ❑ Lung Disease, Asthma or Emphysema
- ❑ Kidney Disease
- ❑ Bleeding Tendency or Blood Disorder
- ❑ Breast Cancer
- ❑ Colon Cancer

EXERCISE WEIGHT LOSS ATTEMPTS

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Health Club					
Walking					
Jogging					
Bicycling					
Swimming					
Aerobics					
Home Equipment					
Trainer					
Other					

Exercise Habits:

How would you describe yourself (or your activity level)?

❑ Sedentary ❑ Minimally Active ❑ Moderately Active ❑ Very Active

Exercise Frequently? _____ times/week

What types of exercise do you engage in? What duration? _____

_____

How many hours of TV do you watch per day? _____

Patient Name:_____ DOB:_____

Each of us has developed connections to food over our lifetime based upon culture, tradition and family patterns. When you think back over your life, what role has food played for you? _____

_____

_____

_____

_____

_____

_____

_____

_____

After you've been successful with weight loss, what role do you think food will play in your life?

_____

_____

_____

_____

_____

Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician			
Gynecologist			
Orthopedist			
Psychiatrist/Psychologist			
Endocrinologist			
Other			

I verify all information contained in this document to be true and factual to the best of my knowledge.

_____ _____

Signature *Date*

Initial Patient Questionnaire reviewed by:

_____ _____

Signature *Date*