Patient Weight Loss Evaluation

Date: ___/___/____

I. Patient Information			
Name:		DOB:	Age:
Address:			
City:		State:	ZIP:
Phone:	Email:		
Gender:	Height:	Weight:	

II. Doctor Information	
Name:	Phone:
Address:	

III. Allergies

☐ Penicillin	☐ Morphine	☐ Dye Allergies	☐ Pet Allergies
☐ Codeine	☐ Aspirin	☐ Nitrate Allergy	☐ Seasonal (Pollen)
☐ Sulfa Drug	☐ Food Allergies	☐ Unknown Allergies	☐ Other: _____

Please describe the allergic reaction you experienced and when it occurred.

_____

IV. Medical Conditions/Diseases

☐ Diabetes	☐ Osteoporosis	☐ High Blood Pressure	☐ High Cholesterol
☐ Heart Disease	☐ Cancer	☐ Kidney Disease	☐ Liver Disease
☐ Thyroid Disease	☐ Anemia	☐ Smoker	☐ Fibromyalgia
☐ Nausea	☐ Vomiting	☐ Acid Reflux	☐ Diarrhea
☐ Constipation	☐ Ulcers	☐ IBS	☐ Diverticulitis
☐ Crohns/IBD	☐ PCOS	☐ Chronic Fatigue	☐ Sulfa Drug

☐ Pregnant (# of months: __)__

☐ Breastfeeding

Other (please list):

_____

Family medical history (please list):

_____

V. Current Prescription Medications

- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticonvulsants
- ☐ Antidepressants
- ☐ Antifungals
- ☐ Aspirin/Ibuprofen
- ☐ Asthma inhalers
- ☐ Beta blockers
- ☐ Chemotherapy
- ☐ Cortisone
- ☐ Diabetic medications
- ☐ Estrogen/Progesterone
- ☐ Diuretics
- ☐ Heart medications
- ☐ High blood pressure
- ☐ Hormone Therapy
- ☐ Laxatives
- ☐ Insulin
- ☐ Oral contraceptives
- ☐ Radiation exposure
- ☐ Sleeping pills
- ☐ Thyroid medication
- ☐ Tylenol/acetaminophen
- ☐ Ulcer medications

Medication Name	Strength	Date Started	Times Per Day

VI. OTC Medications

Check all products you use regularly or occasionally:

Pain relievers:
- ☐ Aspirin
- ☐ Acetaminophen

Anti-inflammatory:
- ☐ Ibuprofen
- ☐ Naproxen

Combination cold products:
- ☐ Cough suppressant
- ☐ Decongestant
- ☐ Antihistamine

Other:
- ☐ Sleep aids
- ☐ Antacids
- ☐ Antidiarrheals
- ☐ Acid blockers
- ☐ Laxatives/stool softeners
- ☐ Diet aids/weight-loss products
- ☐ Other: _____

VII. Supplements

Check all products you are currently using:

- ☐ Vitamins (examples: multiple or single vitamins like B complex, E, C, beta carotene)
- ☐ Minerals (examples: calcium, magnesium, chromium, etc.)
- ☐ Herbs (examples: ginseng, Ginkgo biloba, echinacea, herbal/medicinal teas, tinctures, remedies, etc.)
- ☐ Enzymes (examples: digestive formulas, papaya, bromelain)
- ☐ Nutrition/protein supplements (examples: protein powders, amino acids, fish oils, etc.)
- ☐ Other: _____

VIII. Diet & Lifestyle History

How many meals do you usually eat each day?

Do you skip meals? ☐ Yes ☐ No _____ per day / week	Do you eat out? ☐ Yes ☐ No _____ per day / week
Typical Breakfast:	Lunch:
Dinner:	Snacks:

Patient Name: _____

Food cravings: ☐ Salty ☐ Sweets ☐ Fats ☐ Carbs ☐ Other: _____	Check all that apply: ☐ Kosher ☐ Vegetarian (ovo/lacto) ☐ Vegan ☐ Lactose intolerant
Please indicate if you can tolerate small amounts of the following: ☐ Milk ☐ Cheese ☐ Yogurt	Exercise:_____ per day / week Types: _____
	Indicate your daily activity level (beyond exercise): _____
Occupation: _____	How long is your commute to work?
Your job activity is primarily: ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy	Do you eat meals in your car (to and/or from work)? ☐ Yes ☐ No ☐ Sometimes

List use of:			Qty.	Daily	Weekly	Monthly	Occasionally
Tobacco	☐ No	☐ Yes	_____	☐	☐	☐	☐
Alcohol	☐ No	☐ Yes	_____	☐	☐	☐	☐
Caffeine	☐ No	☐ Yes	_____	☐	☐	☐	☐

IX. Family & Weight History

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Number/Ages of Children:

Which of the following family members have or have had problems with weight control?

☐ Mother ☐ Father ☐ Sibling(s) ☐ Paternal Grandparents ☐ Maternal Grandparents ☐ Children

Were you overweight as a child? ☐ Yes ☐ No	How long has your weight been a problem? _____

List your approximate weight at the following times:

High School Graduation:	Marriage:	Birth of your 1st child:
5 years ago:	1 year ago:	
Maximum adult weight:	Minimum adult weight:	

List any medical problems, injuries, or life events that have significantly affected your weight (include year and weight change):

_____

_____

List any attempted diets: _____

List any medications or diet aids you've used for weight loss:

_____

_____

In your opinion, what contributes most to your excess weight? (Check all that apply)

☐ Portion size	☐ Compulsive eating	☐ Lack of exercise	☐ Stress	☐ Always hungry
☐ Nervous eating	☐ Emotional eating	☐ Eating too much fat/sugar	☐ Boredom	☐ Depression

With whom do you typically eat? ☐ Alone ☐ Family ☐ Other: _____

Who usually does the grocery shopping for your household?

Who usually prepares meals at home?

Patient Name: _____

List any food allergies or intolerances:

Have you ever been a binge eater? ☐ Yes ☐ No

Have you ever had bulimia or anorexia disorder? ☐ Yes ☐ No

You consider yourself: ☐ a structured eater ☐ a haphazard eater

Explain: _____

What are your eating habits that bother you or contribute to your weight problem?

X. Patient Questionnaire

Are you happy with your current weight? ☐ Yes ☐ No

How much weight do you want to lose?

By when do you want to lose it (M/D/Y)?

Why do you want to lose weight?

Check the following symptoms you're experiencing:

	Absent	Mild	Moderate	Severe
Stress	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Weight loss	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Lack of energy	☐	☐	☐	☐
Night blindness	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Dry skin	☐	☐	☐	☐
Decreased appetite	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Nosebleeds	☐	☐	☐	☐
Gingivitis	☐	☐	☐	☐
Muscle pain	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Fluid retention	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Tingling fingers/toes	☐	☐	☐	☐
Numbness	☐	☐	☐	☐
Memory loss	☐	☐	☐	☐
Trouble breathing	☐	☐	☐	☐
Recurrent infections	☐	☐	☐	☐
Light sensitivity	☐	☐	☐	☐
Decreased sex drive	☐	☐	☐	☐

Patient Name: _____

	Absent	Mild	Moderate	Severe
Nervousness	☐	☐	☐	☐
Brittle nails	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Skin rashes	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Altered taste/smell	☐	☐	☐	☐
Increased grey hair	☐	☐	☐	☐
Confusion	☐	☐	☐	☐
Dizziness/lightheadedness	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Decreased alertness	☐	☐	☐	☐
Stiff muscles	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Cold hands and feet	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Increased bleeding	☐	☐	☐	☐
Cramps	☐	☐	☐	☐
Easy bruising	☐	☐	☐	☐

For Physicians Only

In conjunction with any available labs, fax completed health form to **(866) 635-2329.**

Please check whether:

☐ A pharmacist should call the patient for follow up and formulate their dose.

OR

☐ The form is just for our records.

Patient Name: _____