Weight In Gold™

NEW PATIENT HEALTH HISTORY FORM

Name: _____ Date of Visit: _____
Age: _____ Contact Number (optional) _____
Date of Birth: _____ Email Address (required) _____

How did you hear about us? (check all that apply):
☐ Doctor Referral ☐ Instagram ☐ Facebook ☐ Family/Friends ☐ Word of Mouth
☐ Business Cards ☐ Billboards ☐ Other _____

What are your goals as our patient?
☐ _____
☐ _____
☐ _____

Medical History

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gallbladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/heartburn	☐ Infertility
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Thyroid Problems	☐ Arthritis	☐ Polycystic Ovarian Syndrome	☐ Bipolar
☐ Glaucoma	☐ Cancer	☐ Kidney Disease	

☐ Other _____

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

Social History:
Smoking: ☐ Never ☐ Current smoker (_____packs/day) ☐ Past smoker (quit _____years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____drinks per day)

Family History:

Do you have a family history of higher weight?
☐ Yes ☐ No

If yes, who has struggled with their weight?
☐ Mother ☐ Father ☐ Grandparents ☐ Sleep apnea
☐ Siblings ☐ Children

Have you ever been diagnosed with an eating disorder?
☐ Yes ☐ No

If yes, which one? _____

Weight History

When did you first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

What has been your highest weight? _____lbs.

Have there been life events associated with weight gain? (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness
☐ Travel ☐ Injury ☐ Nightshift work ☐ Job Changes ☐ Quitting smoking
☐ Alcohol ☐ Drugs ☐ Other _____
☐ Medications _____

Have you tried any of these programs/methods? (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ Mediterranean ☐ Zone Diet ☐ Medifast ☐ Dash Diet ☐ Paleo Diet
☐ HCG Diet ☐ South Beach ☐ Ornish diet ☐ Keto
☐ Other: _____

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

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion ☐ Belviq ☐ Qsymia ☐ Contrave
☐ Wegovy ☐ Ozempic ☐ Mounjaro ☐ Zepbound
☐ Trulicity ☐ Other _____

Gynecologic History (If Applicable)

Age periods started? _____ Age periods ended (if applicable) _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

Are you breast feeding?

☐ Yes ☐ No

Are you planning a pregnancy in the next year?

☐ Yes ☐ No

Activity History

How many days a week do you engage in moderate or vigorous physical activity (brisk walk or exercise class)?

☐ Never ☐ 1-2 ☐ 3-4 ☐ 5 or more

How many minutes does each bout of exercise last?
☐ 10 minutes or less ☐ 10-20 minutes ☐ 20-30 minutes
☐ 30-60 minutes ☐ More than 60 minutes

Which types of activities do you participate in regularly? (check all that apply)
☐ None ☐ Walking ☐ Running ☐ Biking ☐ Strength training/weightlifting
☐ Yoga ☐ Other: _____

Nutritional History
What do you consider to be your barriers when it comes to managing your weight? (check all that apply)
☐ Stress ☐ Boredom ☐ Anger ☐ Lack of sleep/fatigue ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Cravings ☐ Other: _____

How many meals do you eat in a typical day?
☐ 2 or less ☐ 3 ☐ 3-5 ☐ 6-8 ☐ 8-10+

How many snacks d you eat in a typical day?
☐ 2 or less ☐ 3 ☐ 3-5 ☐ 6-8 ☐ 8-10+

Do you drink caloric beverages such as juice, soda, sweetened tea, coffee with cream?
☐ Yes ☐ No

If yes, how many beverages per day?
☐ 2 or less ☐ 3 ☐ 3-5 ☐ 6-8 ☐ 8-10+

Do you have any food intolerances/restrictions?
☐ Gluten ☐ Dairy ☐ Tree Nuts ☐ Eggs ☐ Soy
☐ Fish ☐ Shellfish ☐ Other: _____

How many hours of sleep do you average per night?
☐ 5 or less ☐ 5-7 ☐ 8 ☐ 8-10+

Do you have trouble falling asleep or staying asleep?
☐ Yes ☐ No

Do you have good social support for healthy lifestyle changes?
☐ Yes ☐ No

If yes, who? _____

Are high stress levels a regular problem for you?
☐ Yes ☐ No

Rate your stress levels:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you use food to cope with stress?
☐ Yes ☐ No

Do you consider yourself an “emotional eater?”
☐ Yes ☐ No

When I smell delicious foods, I find it very difficult to keep from eating, even if I have just finished a meal.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I deliberately take small helpings as a means of controlling my weight.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

Sometimes when I start eating, I just can't seem to stop.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

Being with someone who is eating often makes me hungry enough to eat also.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

When I feel blue, I often overeat.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I get so hungry that my stomach often seems like a bottomless pit.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I am always so hungry so it is hard for me to stop eating before I finish the food on my plate.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I consciously hold back at meals in order not to gain weight.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I am always hungry enough to eat at any time.
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

I consciously eat less than I want?
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

Do you ever go on eating binges though you are not hungry?
☐ Definitely true ☐ Mostly true ☐ Mostly false ☐ Definitely false

How often do you feel hungry?
☐ Only at mealtimes ☐ Sometimes between meals ☐ Often between meals
☐ Almost always

Important Update to Our Appointment Policy

At Weight In Gold, we value the time and commitment of all our patients. To ensure we can provide the best care for everyone, we kindly ask for at least 24 hours' notice if you need to cancel or reschedule your appointment.

This allows us to offer the available time slot to someone else who may need it.

Please Note:
If no notice is given within 24 hours of your appointment, a no-show fee will be applied to your account.

We understand that unexpected situations arise and will always do our best to accommodate you. If you have any concerns or need assistance, don't hesitate to reach out to us.

Thank you for helping us maintain a smooth and efficient care experience for all!

Acknowledgment of 24-Hour Cancellation Policy

I have read and understand the 24-hour cancellation policy and agree to its terms.

Patient Signature: _____
Date: _____