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 _____

Why are you concerned about your weight?
☐ _____
☐ _____
☐ _____

Personal Health History

Past medical history (check all that apply):

☐ Heart attack	☐ Heart failure	☐ Gallbladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/heartburn	☐ Infertility
☐ High cholesterol	☐ Diabetes	☐ Eating disorder	☐ Anxiety
Or Triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Thyroid Problems	☐ Arthritis	☐ Polycystic Ovarian Syndrome	☐ Bipolar
☐ Glaucoma	☐ Cancer	☐ Kidney Disease	☐ Asthma
☐ Irregular heart beat	☐ Heart murmur	☐ Pre-diabetes	☐ Seizures
☐ Gestational diabetes	☐ 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)

Other substances:
☐ Current ☐ Previous ☐ Will discuss with provider

Medication Allergies

Medications List: _____

Review of Symptoms

Do you have any of the following symptoms? Please circle to indicate your answer.

Constitutional: weight gain, fatigue
Respiratory: shortness of breath, snoring, cough, wheezing
Cardiovascular: chest pain, palpitations, leg swelling
GI: constipation, diarrhea, reflux, GERD, abdominal pain
Urinary: increased urination, loss of control of bladder, trouble with erections (men)
Muscular and Skeletal: joint pain, joint swelling, back pain
Neurologic: dizziness, headaches
Endocrine: feeling hotter or colder than you used to or than others in the room, trouble controlling appetite, irregular periods
Psych: trouble sleeping, anxiety, depression
Skin: rashes, darkening of skin on neck or armpits, acne, hair loss, brittle nails or other changes to nails
Neck: pain or swelling

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

Was food always available growing up in your home?
☐ Yes ☐ No ☐ Available but not enough to go around

How many people live with you in your home? _____
What is your occupation? _____

Has a change in occupation impacted your weight?
☐ Yes ☐ No ☐ Not sure

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
What are you doing to prevent pregnancy? _____

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: _____

If so, what was your experience like? _____

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 _____

If so, what was your experience like? _____
Do you have times when you eat more than you plan and feel out of control? If so, how often?
_____

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 does a typical day of eating look like for you? _____
_____
What about weekends and special occasions? _____
_____

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: _____

Sleep and Stress Habits

Do you consider yourself an "emotional eater"?

☐ Yes ☐ No

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

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

Eating Patterns and Behaviors

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

Treatment Approach

Are you interested in medications to help you with your weight?
☐ Yes ☐ No ☐ Unsure

Are you interested in replacing meals with supplements, short or long term, to help with your weight?
☐ Yes ☐ No ☐ Unsure

Are you interested in surgery to help you with your weight?
☐ Yes ☐ No ☐ Unsure

How confident are you that you will be able to lose weight

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10