Appetite Health New Patient Questionnaire

Personal Details

First Name * ____________________

Last Name * ____________________

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Blood Group ____________________

Language ____________________

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Employment Status
- ☐ Employed
- ☐ Full-Time Student
- ☐ Part-Time Student
- ☐ Unemployed
- ☐ Retired

Marital Status
- ☐ Single
- ☐ Married
- ☐ Others

Smoking Status
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Current Weight * ____________________

Current Height * ____________________

Current BMI * ____________________

Primary Contact Details

Caregiver First Name ____________________

Caregiver Last Name ____________________

Email * ____________________

Home Phone ____________________

Mobile Phone ______

Work Phone ______

Extn ______

Primary Phone
- ☐ Mobile Phone
- ☐ Home Phone
- ☐ Work Phone

Address Line1 * ______

Address Line2 ______

City * ______

Country * ______

State * ______

Zip code * ______

Postbox No ______

Emergency Contact Name ______

Emergency Contact Number ______

Extn ______

Names and ages of children: ______

How did you hear about us (please be specific)? ______

Why did you choose to seek nutritional counseling? ______

Weight-Loss History

Please indicate if you have taken any of the following medications to lose weight.

- ☐ Meridia (Sibutramine):
- ☐ Phen-Fen/Redux:
- ☐ Amphetamines:
- ☐ Phentermine (Adipex, Fastin, Pondimin):
- ☐ Xenical (Orlistat/Alli):
- ☐ Belviq (Lorcaserin):
- ☐ Bontril (Phendimetrazine):
- ☐ Desoxyn (Methamphetamine):
- ☐ Didrex (Bensphetamine):
- ☐ Diethylproprion:
- ☐ Qsymia (Phentermine w/ Topiramate):
- ☐ Contrave (Buproprion/Naltrexone):
- ☐ Non-prescription:
- ☐ Others ______

Please provide the following information for the weight-loss medications that you HAVE taken: Start ______

Date & Duration/ Medically Supervised?/ Weight Loss Amount ______________________

Previous Attempts at Weight Loss: *

- [ ] Weight Watchers
- [ ] Jenny Craig
- [ ] Metabolife
- [ ] Medifast
- [ ] NutriSystem
- [ ] Atkins Diet
- [ ] Herbalife
- [ ] SlimFast
- [ ] Grapefruit
- [ ] Optifast
- [ ] Mediterranean
- [ ] South Beach
- [ ] Zone Diet
- [ ] Cabbage
- [ ] Paleo
- [ ] Keto
- [ ] Raw Food
- [ ] Biggest Loser
- [ ] Juicing
- [ ] Vegan/Vegetarian
- [ ] Others ______________________

List any other weight loss methods you have tried: ______________________

Non-Dietary Therapies- Please indicate whether you have tried any of the following weight loss

Exercise: ______________________

Hypnosis: ______________________

Behavior Modification: ______________________

Acupuncture: ______________________

Have you had a previous weight loss surgery? * ☐ Yes ☐ No

If you have had a previous weight loss surgery, please provide the following information: Surgery Type, Date, Surgeon, Weight Loss. ______________________

**Please bring your bariatric health records with you to your first appointment*

Obesity Related Medical History

Do you, or have you ever had any of the following illnesses symptoms? (Select yes or no)

Heart Disease * ☐ Yes ☐ No

Do you, or have you ever had any of the following illnesses symptoms? *

- [ ] Chest Pain
- [ ] Myocardial Infarction (Heart Attack)
- [ ] Coronary bypass surgery
- [ ] Palpitations (abnormal heart beat)
- [ ] Heart valve problems
- [ ] Pulmonary hypertension
- [ ] Congestive heart failure
- [ ] Others ______________________

Stroke * ☐ Yes ☐ No

High Blood Pressure * ☐ Yes ☐ No

Elevated Cholesterol or Triglycerides * ☐ Yes ☐ No

Diabetes Mellitus * ☐ Yes ☐ No

If yes, age of onset: ____________________

Juvenile onset * ☐ Yes ☐ No

Gestational (pregnancy) * ☐ Yes ☐ No

Diet Controlled ☐ Yes ☐ No

Oral Medications ☐ Yes ☐ No

Insulin ☐ Yes ☐ No

Thyroid Disease * ☐ Yes ☐ No

Kidney Disease * ☐ Yes ☐ No

Sleep Apnea * ☐ Yes ☐ No

Do you use a CPAP or BiPap machine? * ☐ Yes ☐ No

Has someone told you that you stopped breathing while you were sleeping? * ☐ Yes ☐ No

Have you had corrective surgery? * ☐ Yes ☐ No

Sleep difficulties:
- ☐ Awakenings at night
- ☐ Daytime drowsiness
- ☐ Observed apnea spells
- ☐ Morning headaches
- ☐ Others ____________________

Have you been diagnosed with any of the following conditions? *
- ☐ Reflux
- ☐ GERD
- ☐ Heartburn
- ☐ Esophagitis
- ☐ Hiatal Hernia
- ☐ Gastroparesis
- ☐ Dysphagia
- ☐ Others ____________________

Asthma * ☐ Yes ☐ No

COPD * ☐ Yes ☐ No

Pseudotumor Cerebri * ☐ Yes ☐ No

Headaches * ☐ Yes ☐ No

If yes, how often? Frequency? ____________________

Do you take prescription medications for headaches? ☐ Yes ☐ No

Do you take over the counter medications for headaches?	☐ Yes	☐ No
Seizures *	☐ Yes	☐ No
Arthritis or Pain in the Ankles/Knees/Hips *	☐ Yes	☐ No
Limits the ability to walk or exercise *	☐ Yes	☐ No
Do you take prescription or over-the-counter medications for arthritis or pain in the Ankles/Knees/Hips? *	☐ Yes	☐ No
Cancer *	☐ Yes	☐ No
If yes, please include type, year of diagnosis, and remission status.	______________________________	
Women: Are you, or could you be pregnant? *	☐ Yes	☐ No
Women: Are you planning on becoming pregnant within 6 months? *	☐ Yes	☐ No
Women: Polycystic Ovarian Syndrome (PCOS) *	☐ Yes	☐ No
Women: Abnormal or Irregular Uterine Bleeding	☐ Yes	☐ No
Venous Stasis	☐ Yes	☐ No
Do you have or experience any of the following conditions?	☐ Leg or ankle swelling/edema ☐ Leg skin color changes or thickening ☐ Others ____________________	☐ Leg ulceration
Deep Vein Thrombosis (Blood clots in leg) *	☐ Yes	☐ No
If yes, year of diagnosis	______________________________	
Pulmonary embolism *	☐ Yes	☐ No
Back/Hip/Knee pain/Sciatica *	☐ Yes	☐ No
If yes, Back/Hip/Knee pain/Sciatica	☐ Limits the ability to walk or exercise ☐ Do you use over the counter medications? ☐ Others ____________________	☐ Do you use prescription medication?
Abdominal Wall Hernia *	☐ Yes	☐ No
If yes, Abdominal Wall Hernia	☐ >1 hernia repairs ☐ Umbilical (belly button) ☐ Others ____________________	☐ Incisional ☐ Hernia currently present
Urinary Incontinence (leakage of urine) *	☐ Yes ☐ Sometimes ☐ Others ____________________	☐ No ☐ With coughing/sneezing/straining

Liver Disease * ☐ Yes ☐ No

Have you ever had hepatitis? * ☐ Yes ☐ No

Have you ever been in treatment for alcohol or drug use? * ☐ Yes ☐ No

If yes, please explain: ____________________

Do you use tobacco? * ☐ Yes ☐ No

If yes, please indicate amount and frequency? ____________________

Do you drink alcohol? * ☐ Yes ☐ No

If yes, please indicate the frequency:
☐ Rarely ☐ Never
☐ Daily ☐ Weekly
☐ Monthly ☐ On weekends
☐ Special Occasions
☐ Others ____________

How many drinks do you usually have? ____________________

Do you use non-legal drugs? * ☐ Yes ☐ No

If yes, please indicate type and frequency. ____________________

Have you ever been treated for an eating disorder (i.e. anorexia, bulimia)? * ☐ Yes ☐ No

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday meals)? * ☐ Yes ☐ No

Have you ever been treated for any of the following? *
☐ Depression ☐ Mood/Personality Disorder
☐ Anxiety ☐ Schizophrenia
☐ Bipolar ☐ Eating Disorder
☐ Others ____________

Are you currently in treatment or any of the above? ☐ Yes ☐ No

If yes, please indicate the name of your physician or therapist. ____________________

Have you ever been hospitalized for mental illness? * ☐ Yes ☐ No

If yes, reason(s) and date(s) of hospitalizations: ____________________

Are you able to walk without assistance? * ☐ Yes ☐ No

If not, do you use a:
☐ Walker ☐ Wheelchair
☐ Cane
☐ Others ____________

Has a physician or medical provider ever told you not to exercise? * ☐ Yes ☐ No

Do you require supplemental oxygen? * ☐ Yes ☐ No

Please list all other medical conditions or illnesses not previously mentioned:

Please list all non-surgical hospitalizations you have experienced as an adult:

Please list all surgical procedures or operations:

Medications: Please list all medications you currently use, including "over the counter" medications, herbal remedies, vitamins and dietary supplements. (Please bring list or medications to visits) *

Do you have allergies to any medications? Yes No
If yes, please list medications and reactions (e.g., rash, breathing difficulty, shock, etc.) *

Nutrition

Food Allergies:

Are you allergic to: *

- ☐ Cocoa
- ☐ Corn
- ☐ Eggs
- ☐ Nuts
- ☐ No food allergies
- ☐ Others ___________________________
- ☐ Milk Protein
- ☐ Soy
- ☐ Fish/Seafood
- ☐ Gluten

Other foods? Please list

Are you sensitive or do you have a problem with: ☐ Monosodium glutamate ☐ Lactose

(MSG)
☐ Salt ☐ Sugar
☐ N/A
☐ Others ____________________________

Please list what you eat during a typical day and at what time:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Drinks: ____________________

Do you use caffeine products (soda, coffee, tea, etc)? ☐ Yes ☐ No

If yes, how much? ____________________

What foods/drinks do you regularly crave? ____________________

Do you cook for yourself/your family? ☐ Yes ☐ No

How many meals per day do you usually eat? ______________________________

Hyperthyroid/Hypothyroid?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Hypoglycemia?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Difficulty losing weight?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Gain weight easily?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Feel cold - hands, feet, all over?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Thinning of hair on scalp, face, or genitals or excessive falling hair?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Under high amounts of stress?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Numbness or Tingling?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Easily Stressed?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Goiter?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Slow wound healing?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Chronic fatigue syndrome?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Chronic infections?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Night sweats?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Teeth grinding?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Gum problems?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Copious saliva?
☐ Yes ☐ No
☐ In Past
☐ Others ______________________

☐ Yes ☐ No

Question	Options	
Sore tongue or lips?	☐ In Past ☐ Others ____________	
Eczema or hives?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Dry or flaky skin and/or scalp?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Itching?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Rashes?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Acne/boils?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Change in skin color?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Lumps or bumps on skin?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Weak nails?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Varicose veins?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Anemia?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Easy bleeding or bruising?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Crave sweets during the day?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Irritable if meals are missed?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Depend on coffee to keep yourself going or started?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Get lightheaded if meals are missed?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Eating relieves fatigue?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
Change in thirst?	☐ Yes ☐ In Past ☐ Others ____________	☐ No
	☐ Yes	☐ No

Appetite Health

Change in appetite? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Greasy or high fat foods cause distress? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Indigestion and fullness lasts 2-4 hours after eating? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Abdominal pain or cramps? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Excessive belching, burping, or bloating? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Gas immediately following meals? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Use antacids? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Offensive breath? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Nausea/vomiting? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Ulcer? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Gallbladder disease? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

History of gallbladder attacks or stones? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Hemorrhoids? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Pancreatitis? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Difficulty digesting fruits and vegetables; undigested foods found in stools? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Feeling that bowels do not empty completely? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Diarrhea? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Constipation? ☐ In Past ☐ Others ____________ ☐ Yes ☐ No

Alternating diarrhea and constipation?	☐ In Past ☐ Others ________________	
Hard, dry, or small stool?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Black stools?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Blood in stools?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Use laxatives frequently?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Bowel movements: How often?	________________________________	
Is this a change?	☐ Yes ☐ No	
Inability to hold urine?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Frequency at night?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Frequent UTI's?	☐ Yes ☐ In Past ☐ Others ________________	☐ No
Kidney stones?	☐ Yes ☐ In Past ☐ Others ________________	☐ No

Diet Survey

How many alcoholic beverages do you consume per week? ________________________________

How many caffeinated beverages to you consume per week? ________________________________

How many times do you eat out per week? ________________________________

How many times a week do you work out? ________________________________

List the three worst foods you eat during the average week:

____

____

____

____

List the three healthiest foods you eat during the average week:

____

____

____

____