North End Weight Loss Logo 3

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail

**Please indicate the best number to reach you and leave a message.**

(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Home Work

(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Home Work

Employment status ⁪Employed ⁪Not Employed ⁪Retired

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any special need? ⁪ Yes ⁪ No If yes please specify: \_\_\_wheel chair \_\_\_\_\_\_\_\_\_\_\_\_\_\_other

**Emergency Contact** (Please Print)

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⁪ Insurance

⁪ Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide your Primary Care Physician’s information**

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why did you decide it was time to lose weight and consider Semaglutide?**

⁪ Deteriorating health

⁪ Poor quality of life

⁪ Unable to participate in family activities

⁪ Advise of physician

⁪ Insurance/monetary issues

⁪ Other If other, please specify below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-morbid/medical conditions**

Have you been diagnosed or treated for the following by a physician?

⁪ Diabetes

⁪ Sleep Apnea ⁪ High Blood Pressure

⁪ Cardiovascular Problems

⁪ Gastric or Stomach Problems

⁪ Heart Burn/Acid Reflux

⁪ Joint Degeneration

⁪ Depression

Any other medical conditions that you have been diagnosed or treated for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY – Please list relationship to you**

Alcoholism\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Bleeding Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Diabetes Mellitus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Liver Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Lung Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Malignant Hyperthermia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Mental Illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

Obesity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Yes ○ No

**Family History of Cancer** (Type) ○ Yes ○ No

○Breast ○Uterine ○Ovarian ○Prostate ○Colon ○Lung ○Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History of Cancer** (Type) ○ Yes ○ No

○Breast ○Uterine ○Ovarian ○Prostate ○Colon ○Lung ○Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like to share that you feel might be applicable?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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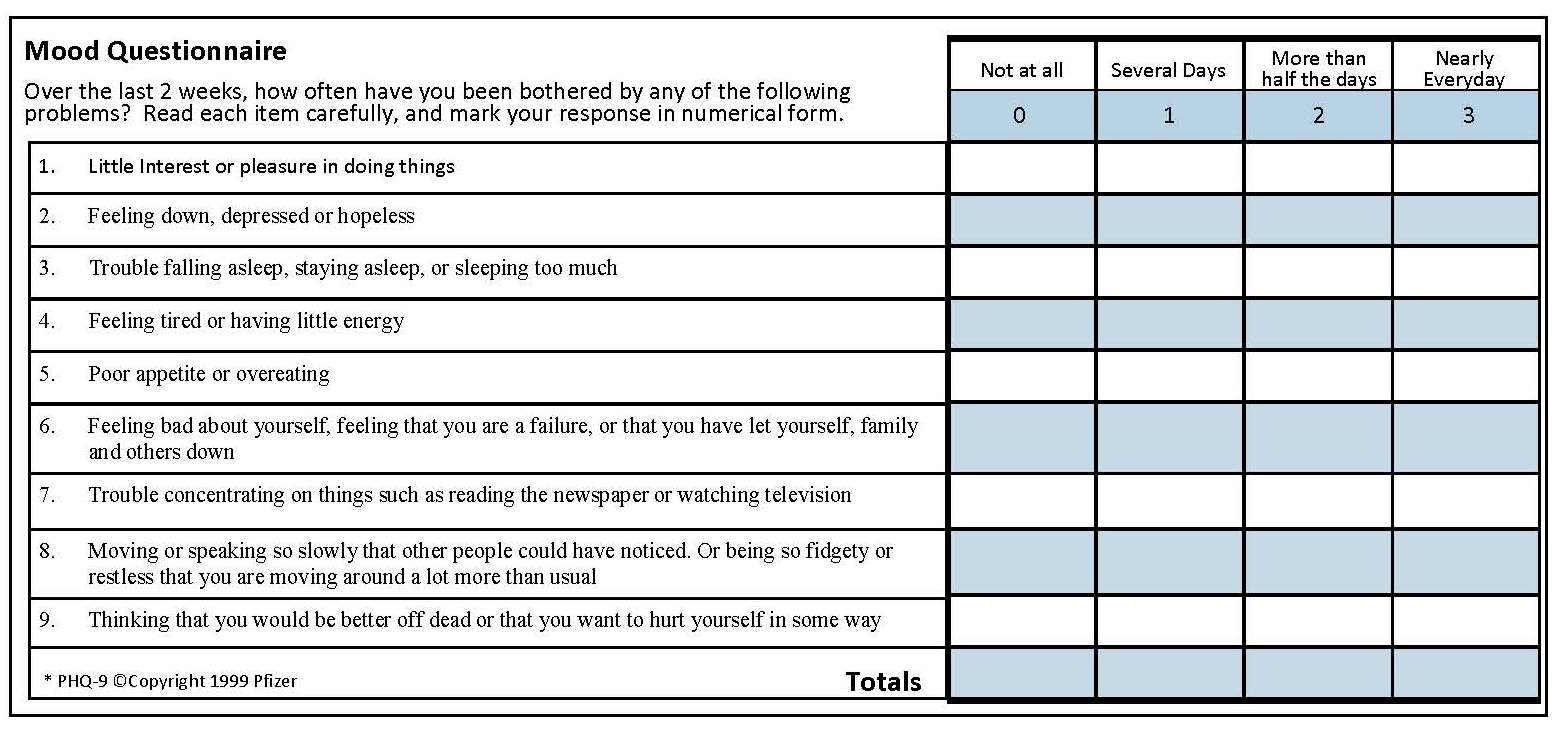
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Medication Information that also includes vitamins, mineral and herbal supplements (please provide over the counter as well as natural or herbal medications. Example: multi-vitamin, iron, vit C, etc.).

**Allergies – Foods and/or medicines:** Please list any allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Medication** | **Dose** | **Frequency** |
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**Total Score Depression Severity** Score\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. None **\*Determined by provider**
  2. Mild
  3. Moderate
  4. Moderately Severe

20-27 Severe

**SURGICAL/HOSPITALIZATION RECORD Month/Year**

List of Surgeries and Date/Year

Surgery Performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Performed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**Bladder/Kidney**

Kidney Stones ○Yes ○No

Frequent UTIs ○Yes ○No

Loss of bladder control (leakage) ○Yes ○No

Kidney Insuffiency ○Yes ○No

Kidney Failure ○Yes ○No

Dialysis ○Yes ○No

**For Men:** PSA test in the last year ○Yes ○No

Prostate problems ○Yes ○No

**Blood**

Blood clot in leg ○Yes ○No

Blood Clot in Lungs(pulmonary embolism) ○Yes ○No

Bleeding disorder ○Yes ○No

Blood transfusion ○Yes ○No

Blood thinning medicine ○Yes ○No

Anemia (vitamin B12 deficient) ○Yes ○No

Anemia (iron deficient) ○Yes ○No

HIV ○Yes ○No

Low platelets (thrombocytopenia) ○Yes ○No

**Cardiovascular**

Angina (chest pain with activity) ○Yes ○No

Heart attack ○Yes ○No

Previous Angiogram ○Yes ○No

Stent Placement ○Yes ○No

PTCA (balloon angioplasty) ○Yes ○No

Heart murmur ○Yes ○No

Rheumatic fever/valve damage ○Yes ○No

Rhythm disturbance/palpitations ○Yes ○No

High blood pressure ○Yes ○No

Congestive heart failure ○Yes ○No

Ankle swelling ○Yes ○No

Venous Stasis ○Yes ○No

Ankle/Leg Ulcers ○Yes ○No

Cramping in legs when walking ○Yes ○No

**Respiratory**

Asthma ○Yes ○No

COPD ○Yes ○No

Oxygen Dependent ○Yes ○No

Recent Bronchitis ○Yes ○No

Pneumonia ○Yes ○No

Chronic cough ○Yes ○No

Short of breath ○Yes ○No

Tuberculosis ○Yes ○No

Snoring ○Yes ○No

Sleep apnea ○Yes ○No

Hypoventilation syndrome ○Yes ○No

**Constitutional**

Fevers ○Yes ○No

Night Sweats ○Yes ○No

Anemia ○Yes ○No

Weight Loss ○Yes ○No

Chronic fatigue ○Yes ○No

Hair Loss ○Yes ○No

**Endocrine**

Hypothyroid (low) ○Yes ○No

Hyperthyroid (high/overactive) ○Yes ○No

Goiter ○Yes ○No

Parathyroid ○Yes ○No

Elevated cholesterol ○Yes ○No

Elevated triglycerides ○Yes ○No

Low blood sugar ○Yes ○No

Diabetes (managed by diet or pills) ○Yes ○No

Diabetes (needing insulin shots) ○Yes ○No

“Prediabetes” with elevated blood sugar ○Yes ○No

Gout ○Yes ○No

High calcium level ○Yes ○No

**Gastrointestinal**

Heartburn/ Acid Reflux ○Yes ○No

Hiatal hernia ○Yes ○No

Ulcers ○Yes ○No

Unusual vomiting ○Yes ○No

Change in bowel habit ○Yes ○No

Diarrhea ○Yes ○No

Constipation ○Yes ○No

Gastritis ○Yes ○No

Blood in stool ○Yes ○No

Irritable bowel ○Yes ○No

Colitis ○Yes ○No

Crohns ○Yes ○No

Polyps ○Yes ○No

Cirrhosis/hepatitis ○Yes ○No

Gallbladder problems ○Yes ○No

Jaundice ○Yes ○No

Pancreatic disease ○Yes ○No

**Head and Neck**

Wear contacts/glasses ○Yes ○No

Vision problems ○Yes ○No

Hearing problems ○Yes ○No

Swallowing difficulty ○Yes ○No

Dentures/partial ○Yes ○No

Missing teeth ○Yes ○No

Oral sores ○Yes ○No

Hoarseness ○Yes ○No

**Musculoskeletal**

Arthritis ○Yes ○No

Joint Pain ○Yes ○No

Back Pain ○Yes ○No

Shoulder Pain ⁪ Right ⁪ Left ○Yes ○No

Ankle Pain ⁪ Right ⁪ Left ○Yes ○No

Knee Pain ⁪ Right ⁪ Left ○Yes ○No

Hip Pain ⁪ Right ⁪ Left ○Yes ○No

Foot Pain ⁪ Right ⁪ Left ○Yes ○No

Plantar fasciitis ○Yes ○No

Carpal tunnel syndrome ○Yes ○No

Limited ability to walk ○Yes ○No

Sciatica ○Yes ○No

Muscle pain spasm ○Yes ○No

Broken bones ○Yes ○No

Nerve injury ○Yes ○No

Muscular dystrophy ○Yes ○No

**Neurologic**

Balance disturbance ○Yes ○No

Seizure or convulsions ○Yes ○No

Weakness ○Yes ○No

Stroke ○Yes ○No

Alzheimer’s ○Yes ○No

Loss of vision from pressure in the brain ○Yes ○No

Multiple Sclerosis ○Yes ○No

Frequency severe headaches/migraines ○Yes ○No

**Skin**

Rashes under skin folds ○Yes ○No

Frequent skin infections ○Yes ○No

Keloids (excessively raised scars) ○Yes ○No

Poor wound healing ○Yes ○No

**Psychiatric**

Anxiety ○Yes ○No

Depression ○Yes ○No

Anorexia (starvation to control weight) ○Yes ○No

Bulimia (excessive vomiting to control weight) ○Yes ○No

Bipolar disorder (“manic-depression”) ○Yes ○No

Alcoholism ○Yes ○No Drug dependency ○Yes ○No

Schizophrenia ○Yes ○No

Other psychiatric problems ○Yes ○No

Have you ever attempted suicide? ○Yes ○No

Have you ever taken medications for psychiatric problems or for depression? ○Yes ○No

\*If yes, please list medication, side effects and duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WEIGHT HISTORY SECTION**

**Unsupervised diet attempts that you did on your own.** (Check all that apply and enter the weight lost, weight regained, duration of time spent following the diet and number of attempts)

⁪ No unsupervised diet attempts of any kind.

**Diet** Please use Month/Year **From To Lost Regain Attempts**

* Physician Supervised \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Nutri-Systems \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Optifast \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Weight Watchers \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Jenny Craig \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Other 1:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_
* Other 2:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_lbs. \_\_\_\_\_\_lbs. \_\_\_\_\_\_\_

**Medications Prescribed for Weight Loss** (Medications may be listed both as generic and name brand. Check medications that you have taken for weight loss.)

* No Weight Loss medications.

**Medication**

⁪ Dexatrim ⁪ Phentermine ⁪ PhenDiet Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did these medications work for you?⁪ Yes⁪ No

Eating Habits**:** (check all that apply)

□ Scheduled meal eater

□ No set schedule

□ Binge eating/compulsive eater

□ Emotional eater

□ Night eater

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Rapid eater □ Junk food eater

□ Meat and potatoes type

□ Sweet eater

□ Fast food eater

□ Large/multiple servings

1. **Activity:** (check one)

□ Restricted (Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Sedentary

□ Low active

□ Active

□ Very active

1. **Why do you eat?** (check one or more)

□ Physical hunger

□ Out of emotion

□ Sight and/or smell of food

□ Boredom

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What reasons do you feel contribute to you being overweight?** (check all that apply)

□ Inactivity

□ Emotional well-being

□ Over consumption

□ Eating too fast

□ Medications

□ Skipping meals and then overeating

□ Eating oversized portions

□ Eating when bored

□ I always clean my plate

□ Grazing / snacking

□ Too many sweets / starches

□ Eating on the run

□ Eating as a self reward

□ Eating for comfort

□ Can’t tell when you have eaten enough

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Why do you want to lose weight? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Weight Loss Goals and Expectations

-How much weight do you expect/hope to lose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-How fast do you expect to lose weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-What goals would you like to set for yourself?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any additional information or comments you would like to share?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *By signing above, you agree that all information provided is accurate to the best of your knowledge.*

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Representative Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_