APMWellness

NAME:

WEIGHT MANAGEMENT PROGRAM NEW PATIENT QUESTIONNAIRE

Allergies

Drug / Substance	Reaction

Medications

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the-counter)?

Medication / Strength	Dose / Frequency

Personal Health History

Please mark “yes” if you have been diagnosed with any of the following or “no” if youhave not.

Diagnosis	Yes	No		Diagnosis	Yes	No
Irregular Heart Beat				Liver Disease/ Hepatitis		
Heart Murmur				Kidney Stones		
Heart Attack				Kidney Disease		
High Cholesterol				Glaucoma		
Diabetes/ Prediabetes/ Gestational Diabetes				Gallstones		
High Blood Pressure				GERD/Reflux		
Congestive HeartFailure				PCOS		
Stroke				Thyroid Cancer		
Asthma				Thyroid Problems		
Emphysema/COPD				Blood Clot in Legs		
Sleep Apnea				Blood Clot in Lungs		
Gout				Ulcers in Bowel/ Stomach		
Arthritis				Bleeding from Bowels		
Epilepsy/Seizures				Prostate Problems		
Anxiety				Skin Disease		
Depression				Bleeding Problems		
Eating Disorder				Anemia		
Alcohol Abuse				Cancer (and type)		
Substance Abuse				Other:		

Additional information:

Surgical History

Please mark “yes” if you have had any of the following and indicate the date. If thisdoes not apply, please leave blank.

Surgery	Yes	Date		Surgery	Yes	Date
Bariatric Surgery				Tonsils Surgery		
C-Section				Open Heart Surgery/ Catheterization		
Appendectomy				Gallbladder Surgery		
Abdominal Surgery				Broken Bone Repair		
Joint Scope Surgery				Joint Replacement		
Back Disc Surgery				Prostate Surgery		
Hernia Surgery				Vasectomy		
Hysterectomy				Eye Surgery		
Other:						

Family History

Please indicate if a family member has been diagnosed with any of the following by marking “yes” and including their relation.

Medical Problem	Yes	Relation		Medical Problem	Yes	Relation
Heart Attack				High Blood Pressure		
High Cholesterol				Diabetes/High BloodSugar		
Thyroid Problems				Thyroid Cancer		
Asthma				Liver Disease		
Kidney Disease				Arthritis		
Glaucoma				Stroke		
Epilepsy/Seizures				Bleeding Problems		
Anxiety				Cancer (and type)		
Depression				Other:		
Alcohol Abuse				Other:		

Social History

When was your last physical or preventative health screening?

Smoking, Alcohol, Drugs

The following questions are very important and strictly confidential. Please answer them accurately.

	Yes	No	How much?	How often?
Do you currently smoke, use E Cigarettes, or Vape?				
Have you ever smoked, used E Cigarettes,or Vaped?				
Do you, or have you, used smokeless tobacco?				
Do you drink alcohol?				
Do you have a history of alcohol abuse?				
Do you use marijuana?				
Do you use drugs?				
Have you used in the past?				

Female Patients

What are you doing to prevent pregnancy?

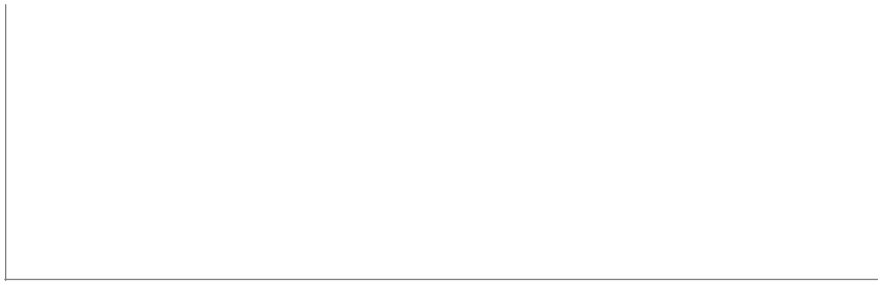
Weight Intake

Welcome! In order to customize a plan just for YOU, it helps us to have some more details. Please fill out this questionnaire with your demographics and history before your visit so we can make the most of our time together.

Weight History

What has your weight been like over time? Draw a chart. Note anything you feel has been significant to help you lose weight or reasons you might have gained weight.

Weight



Year or Event

Have there been things that have helped you lose weight in the past? If so, what?

WHY do you want to lose weight?

Do you have times when you eat more than you plan and feel out of control? If so, how often?

Please answer “yes” or “no”.

Do you snore? YES NO

Do people tell you that you stop breathing in your sleep? YES NO

Do you have headaches in the morning? YES NO

Are you constantly sleepy? YES NO

Can you fall asleep anywhere? YES NO

In the past two weeks, how often have you been bothered by the following problems? Please circle your answer.

	Not at all	Several Days	More thanhalf the days	Nearly Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed,or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?	0	1	2	3

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

IF YOU SAID YES TO QUESTION #1
ON AVERAGE, HOW MANY TIMES A WEEK WOULD YOU SAY YOU HAVE EXCESSIVE OVEREATING EPISODES?

☐ 1-3 ☐ 4-7 ☐ 8-13 ☐ 14+

Are you interested in medications to help you lose weight?

Not interested Very Interested

1 2 3 4 5 6 7 8 9 10

Are you interested replacing most or all meals with meal supplements like shakes and bars tohelp you lose weight?

Not interested Very Interested

1 2 3 4 5 6 7 8 9 10

Are you interested in surgery to help you lose weight?

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

Not Confident Very Confident

1 2 3 4 5 6 7 8 9 10

Are there any foods you CANNOT eat?

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 appetitecontrolled, irregular periods (women)

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

ENT: nasal congestion, dry mouth Eyes: eye pain, vision changes Heme: increased bruising, bleeding

Allergy/Immunology: hives, seasonal allergies

What does a typical day of eating look like for you?

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

Drinks:

What about weekends and special occasions?

What type, if any, exercise do you currently do?