

# ACTION Weight Management Centers

## Patient Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

### Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No  
Explain a "no" answer:
2. Are you under a doctor's care at the present time? Yes No  
If yes, for what?
3. Are you taking any medications at the present time? Yes No

### Prescription Drugs: (List all)

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_

Over-the-Counter medications and supplements: Yes No  
If yes, list all.

Product \_\_\_\_\_ Dosage \_\_\_\_\_

4. Are you taking any vitamins at the present time? Yes No  
Please check all that apply:

Multivitamin                       Vitamin D                       Iron  
 Vitamin B-12                       Calcium with Vitamin D                       Other \_\_\_\_\_  
 Calcium                       Vitamin A, D, E Combo                       Other \_\_\_\_\_

5. Do you have any allergies? Yes No

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Please check all that apply:

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Medications                | <input type="checkbox"/> Foods        | <input type="checkbox"/> Latex                    |
| <input type="checkbox"/> Antibiotics<br>Type: _____ | <input type="checkbox"/> Peanuts      | <input type="checkbox"/> House dust mites         |
| <input type="checkbox"/> Aspirin                    | <input type="checkbox"/> Seafood      | <input type="checkbox"/> Animal dander and saliva |
| <input type="checkbox"/> Narcotics                  | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Tape                     |
| <input type="checkbox"/> Other: _____               | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Venoms from insect bites |
| <input type="checkbox"/> Other: _____               | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____             |

6. Do you have a history of Diabetes? Yes    No  
At what age: \_\_\_\_\_
7. Do you have a history of frequent headaches? Yes    No  
Migraines?    Yes    No    Medications for Headaches: \_\_\_\_\_
8. Do you have a history of constipation (difficulty in bowel movements)? Yes    No
9. Do you have any implanted devices? Yes    No  
Please check all that apply:  
 Spinal Cord Stimulator                       Baclofen Pump  
 Pacemaker     Other \_\_\_\_\_
10. Gynecologic History:  
Pregnancies:    Number: \_\_\_\_\_    Dates: \_\_\_\_\_  
Natural Delivery or C-Section (specify): \_\_\_\_\_  
Menstrual:    Onset: \_\_\_\_\_  
                  Duration: \_\_\_\_\_  
                  Are they regular:    Yes    No  
                  Pain associated:    Yes    No  
                  Last menstrual period: \_\_\_\_\_
- Have you had Hormone Replacement Therapy? Yes    No  
What: \_\_\_\_\_
- Are you taking any birth control pills? Yes    No  
Type: \_\_\_\_\_
- Last Check Up: \_\_\_\_\_
11. Serious Injuries: Yes    No  
Specify (list all)    Date
12. Have you had any **Non-Bariatric** surgical procedures? Yes    No

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Please check all that apply and include date of procedure.

<u>Procedure:</u>	<u>Date:</u>
<input type="checkbox"/> Abdominal exploration	_____
<input type="checkbox"/> Appendectomy	_____
<input type="checkbox"/> Bowel resection	_____
<input type="checkbox"/> Small bowel	
<input type="checkbox"/> Colon	
<input type="checkbox"/> Cancer surgery	_____
For: _____	
<input type="checkbox"/> Breast biopsy	_____
<input type="checkbox"/> Benign	
<input type="checkbox"/> Cancerous	
<input type="checkbox"/> Caesarian section	_____
<input type="checkbox"/> Tubal ligation	_____
<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Oophorectomy (Ovary removal)	_____
<input type="checkbox"/> Mastectomy/operation for breast cancer	_____
<input type="checkbox"/> Heart angioplasty and/or stent	_____
<input type="checkbox"/> Heart catheterization	_____
<input type="checkbox"/> Other heart procedure	_____
<input type="checkbox"/> Colonoscopy	_____
<input type="checkbox"/> Upper endoscopy	_____
<input type="checkbox"/> Hernia repair	_____
<input type="checkbox"/> Groin	
<input type="checkbox"/> Abdominal	
<input type="checkbox"/> Hiatal	
<input type="checkbox"/> Back operation/laminectomy	_____
<input type="checkbox"/> Joint replacement	_____
<input type="checkbox"/> Hip(s)	
<input type="checkbox"/> Knee(s)	
<input type="checkbox"/> Knee arthroscopy (exploratory surgery)	_____
<input type="checkbox"/> Operation for reflux (GERD)	_____
<input type="checkbox"/> Cholecystectomy (Gallbladder removal)	_____
<input type="checkbox"/> Open	
<input type="checkbox"/> Laparoscopic	
<input type="checkbox"/> Other operations (please list below)	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. Have you had any **Bariatric** surgical procedures? Yes    No

Please check all that apply and include information

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<u>Procedure:</u>	<u>Open or Laparoscopic?</u>	<u>Date:</u>	<u>Original Weight:</u>	<u>Weight Lost:</u>
<input type="checkbox"/> Gastric Bypass (R-n-Y)	_____	_____	_____	_____
<input type="checkbox"/> Biliopancreatic Diversion (BPD)	_____	_____	_____	_____
<input type="checkbox"/> BPD with Duodenal Switch	_____	_____	_____	_____
<input type="checkbox"/> Adjustable Gastric Band	_____	_____	_____	_____
<input type="checkbox"/> Vertical Banded Gastroplasty	_____	_____	_____	_____
<input type="checkbox"/> Sleeve Gastrectomy	_____	_____	_____	_____
<input type="checkbox"/> Non-adjustable Gastric Band	_____	_____	_____	_____
<input type="checkbox"/> Intestinal Bypass	_____	_____	_____	_____
<input type="checkbox"/> Gastric Pacing	_____	_____	_____	_____
<input type="checkbox"/> Revisions to:	_____	_____	_____	_____
_____	_____	_____	_____	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### 14. Family History:

Check if any blood relative ever had any of the following conditions:

<u>Condition:</u>	<u>Grandparents:</u>	<u>Mother</u>	<u>Father:</u>	<u>Siblings:</u>	<u>Children:</u>
Asthma:					
Cancer:					
Glaucoma:					
Epilepsy:					
High Blood Pressure:					
Heart Attack before age 50:					
Heart Disease:					
Kidney Disease:					
Stroke:					
Arthritis:					
Reflux:					
Diabetes:					
Blood clots:					
History of Bleeding:					
Depression:					
Other Psychiatric Disorder:					
Overweight:					
Obese:					
Morbidly obese:					
Obesity surgery:					

Family History continued:

Race

African American  
 Asian

Native American or Alaska Native  
 Native Hawaiian or other Pacific Islander

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Caucasian                       Other: \_\_\_\_\_  
 Hispanic

## Children

Date of Birth	Gender (M/F)	Obese (Y/N)
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____
6.) _____	_____	_____

## 15. Social History:

-Occupation: \_\_\_\_\_

Employment status: (Please check one)

Full time                       Homemaker                       Retired  
 Part time                       Student                       Disability  
 Self employed                       Unemployed                       Not specified

-Marital Status: (please check one)

Single                       Separated  
 Married                       Divorced  
 Domestic Partner                       Widowed

-Do you drink alcohol? Yes      No

What? \_\_\_\_\_ How much daily? \_\_\_\_\_ Weekly? \_\_\_\_\_

-Smoking Habits: (please check only one)

You have never smoked cigarettes, cigars or a pipe.  
 You rarely (socially) smoke cigarettes, cigars or a pipe.  
 You occasionally (1x per week) smoke cigarettes, cigars or a pipe.  
 You quit smoking \_\_\_\_\_ years ago and have not smoked since.  
 You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.  
 You smoke 20 cigarettes per day (1 pack).  
 You smoke 30 cigarettes per day (1-1/2 packs).  
 You smoke 40 cigarettes per day (2 packs).

-Substance Abuse:

None       Rare       Occasional       Frequent

**Past Medical History:** (check all that apply)

Glaucoma                       Chest Pain                       Swelling Feet  
 Polio                       Measles                       Tonsillitis  
 Jaundice                       Mumps                       Pleurisy

# ACTION Weight Management Centers

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Kidney Disease                                      | <input type="checkbox"/> Scarlet Fever               | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Lung Disease  | <input type="checkbox"/> Whooping Cough              | <input type="checkbox"/> Chicken Pox             |
| <input type="checkbox"/> Rheumatic Fever                                     | <input type="checkbox"/> Bleeding Disorder           | <input type="checkbox"/> Nervous Breakdown       |
| <input type="checkbox"/> Ulcers  | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Heart Valve Disorder        | <input type="checkbox"/> Heart Disease           |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Gallbladder Disorder        | <input type="checkbox"/> Psychiatric Illness     |
| <input type="checkbox"/> Drug Abuse  | <input type="checkbox"/> Eating Disorder             | <input type="checkbox"/> Alcohol Abuse           |
| <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Malaria                     | <input type="checkbox"/> Typhoid Fever           |
| <input type="checkbox"/> Cholera   | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Blood Transfusion       |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Angina                  |
| <input type="checkbox"/> Apnea   | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Back pain               |
| <input type="checkbox"/> Crohn's Disease                                     | <input type="checkbox"/> Deep vein thrombosis        | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Diverticulosis                                      | <input type="checkbox"/> Endometriosis               | <input type="checkbox"/> Epilepsy/seizures       |
| <input type="checkbox"/> Fatty Liver   | <input type="checkbox"/> Gallstones                  | <input type="checkbox"/> GERD                    |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> High cholesterol        |
| <input type="checkbox"/> Irregular menses                                    | <input type="checkbox"/> Irritable bowel syndrome    | <input type="checkbox"/> Joint Pain              |
| <input type="checkbox"/> Kidney stones                                       | <input type="checkbox"/> Leg swelling/ulcers         | <input type="checkbox"/> Malnutrition            |
| <input type="checkbox"/> Plantar fasciitis                                   | <input type="checkbox"/> Pseudotumor cerebri         | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Thyroid disease                                     | <input type="checkbox"/> Ulcerative colitis          | <input type="checkbox"/> Urinary leakage         |
| <input type="checkbox"/> Dyspnea on exertion<br><i>(shortness of breath)</i> | <input type="checkbox"/> Polycystic ovarian syndrome |  |

## **Review of Systems:**

*Please read carefully and circle Yes/No. If you answered yes to any question, please check all that apply. If you are uncertain about a condition, please circle No.*

### **1. Cardiovascular Disease**

- |  |     |    |  |
|--|-----|----|--|
| Hypertension   | Yes | No |  |
| <input type="checkbox"/> Borderline, no medication             |     |    |  |
| <input type="checkbox"/> Diagnosed but not on medication       |     |    |  |
| <input type="checkbox"/> Treatment with a single medication    |     |    |  |
| <input type="checkbox"/> Treatment with multiple medications   |     |    |  |
| <input type="checkbox"/> Poorly controlled by medications      |     |    |  |
|  |     |    |  |
| Enlarged heart by ultrasound                                   | Yes | No |  |
| Shortness of breath:   |     |    |  |
| <input type="checkbox"/> (Class I) With exercise               |     |    |  |
| <input type="checkbox"/> (Class II) With ordinary activity     |     |    |  |
| <input type="checkbox"/> (Class III) Walking less than 1 block |     |    |  |
| <input type="checkbox"/> (Class IV) At rest                    |     |    |  |

### **Cardiovascular Disease continued**

- |  |     |    |  |
|--|-----|----|--|
| Ischemic Heart Disease   | Yes | No |  |
| <input type="checkbox"/> Abnormal EKG, no active ischemia                    |     |    |  |
| <input type="checkbox"/> History of heart attack or anti-ischemia medication |     |    |  |

# ACTION Weight Management Centers

- PCI or CABG surgery
- Active ischemia

- |   |     |    |
|---|-----|----|
| Arrhythmia  | Yes | No |
| <input type="checkbox"/> Occasional skipped beats by EKG or other test                              |     |    |
| <input type="checkbox"/> Episodes of fast heartbeat without exercise, by EKG or holter monitor test |     |    |
| <input type="checkbox"/> Atrial fibrillation  |     |    |
| <input type="checkbox"/> Pacemaker  |     |    |

- |  |     |    |
|--|-----|----|
| Additional Heart Problems and Coronary Artery Disease                                      | Yes | No |
| <input type="checkbox"/> Heart bypass  |     |    |
| <input type="checkbox"/> Heart stent (coronary artery stent)                               |     |    |
| <input type="checkbox"/> Heart valve problem or replacement<br>(list type of valve: _____) |     |    |
| <input type="checkbox"/> Medication for angina (ischemia)                                  |     |    |
| <input type="checkbox"/> Blood thinner for heart   |     |    |
| <input type="checkbox"/> Oxygen for heart or lungs   |     |    |

- |   |     |    |
|---|-----|----|
| Deep Vein Blood Clot or Pulmonary Embolism  | Yes | No |
| <input type="checkbox"/> Clinical suspicion but unconfirmed   |     |    |
| <input type="checkbox"/> DVT associated with a risk factor (trauma or surgery) but resolved with blood thinning medications |     |    |
| <input type="checkbox"/> Recurrent DVT with long-term blood thinning medication   |     |    |
| <input type="checkbox"/> Previous blood clot to lungs   |     |    |
| <input type="checkbox"/> Recurrent pulmonary embolism, disability and decreased function, or past hospitalization           |     |    |
| <input type="checkbox"/> Vena Cava filter   |     |    |

- |  |     |    |
|--|-----|----|
| Leg Edema  | Yes | No |
| <input type="checkbox"/> Intermittent lower extremity edema, not requiring medical treatment                                     |     |    |
| <input type="checkbox"/> Symptoms requiring medical treatment, diuretics, elevation, or a support base                           |     |    |
| <input type="checkbox"/> Stasis dermatitis, pigmentation, or Cellulites (legs swelling all of the time or at the end of the day) |     |    |
| <input type="checkbox"/> Stasis ulcers   |     |    |
| <input type="checkbox"/> Disability, decreased function, or past hospitalization   |     |    |

## Cardiovascular Disease continued

- |   |     |    |
|---|-----|----|
| Peripheral Vascular Disease                                     | Yes | No |
| <input type="checkbox"/> Asymptomatic with bruit                |     |    |
| <input type="checkbox"/> Claudication, anti-ischemic medication |     |    |
| <input type="checkbox"/> Mini-stroke                            |     |    |

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- Procedure for peripheral vascular disease
- Stroke or loss of tissue due to ischemia

Angina Assessment	Yes	No
<input type="checkbox"/> Chest pain with extreme exercise (e.g., running)		
<input type="checkbox"/> Chest pain with moderate activity		
<input type="checkbox"/> Chest pain with minimal activity or at rest		
<input type="checkbox"/> Unstable angina		

Have you had a superficial vein blood clot or phlebitis?	Yes	No
Have you had multiple miscarriages?	Yes	No
Do you take birth control medication or estrogen?	Yes	No
Do you take blood thinning medication?	Yes	No
Do you have lupus anticoagulant?	Yes	No
Do you have factor V leiden disorder?	Yes	No
Do you have an abnormality in protein C or protein S?	Yes	No

## 2. Endocrine Disease

Glucose Metabolism	Yes	No
<input type="checkbox"/> Elevated fasting glucose or borderline diabetes		
<input type="checkbox"/> Diabetes, controlled with oral medication (not insulin)		
<input type="checkbox"/> Diabetes, controlled with oral and/or injectable medication (not insulin)		
<input type="checkbox"/> Poorly controlled or severe complications (i.e., retinopathy, neuropathy, renal failure, blindness)		
<input type="checkbox"/> Number or oral medications that you take: _____		

Dyslipidemia (elevated cholesterol/triglycerides)	Yes	No
<input type="checkbox"/> Present, no treatment required		
<input type="checkbox"/> Controlled with lifestyle change, including Step 1 or Step 2 diet		
<input type="checkbox"/> Controlled with single medication		
<input type="checkbox"/> Controlled with multiple medications		
<input type="checkbox"/> Not controlled		

### Endocrine Disease continued

Polycystic Ovarian Syndrome	Yes	No
<input type="checkbox"/> No treatment		
<input type="checkbox"/> Birth control pills/patch/ring or anti-androgen medication		
<input type="checkbox"/> Metformin, Avandia, or Actos		

# ACTION Weight Management Centers

- Combination therapy
- Infertility

Collagen Vascular Disorders Yes    No  
 Scleroderma  
 Lupus  
 Rheumatoid arthritis  
 Other: \_\_\_\_\_

Gout or Hyperuricemia Yes    No  
 Gout or hyperuricemia, no symptoms  
 Gout or hyperuricemia, on medications  
 Uric acid crystals in joints  
 Destructive joints  
 Disability, unable to walk

### 3. Respiratory Disease

Sleep Apnea Yes    No  
 Sleep apnea symptoms, but a negative sleep study or study was not done  
 Sleep apnea diagnosis by sleep study, but no oral appliance (CPAP)  
 Sleep apnea requiring oral appliance (CPAP)  
 Sleep apnea with significant hypoxia or oxygen dependent  
 Sleep apnea with complications (i.e., pulmonary hypertension)

Obesity Hypoventilation Yes    No  
 Hypoxemia (low oxygen) or hypercarbia (high carbon dioxide) on room air  
 Severe hypoxemia or hypercarbia  
 Pulmonary hypertension  
 Right heart failure  
 Right heart failure and left ventricular dysfunction  
 Bipap machine

Have you been tested for snoring? Yes    No

### Respiratory Disease continued

CPAP use? Yes    No  
 CPAP setting is 0-5  
 CPAP setting is 5-10  
 CPAP setting is 10-15  
 CPAP setting is greater than 15

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Pulmonary Hypertension	Yes	No
<input type="checkbox"/> Symptoms of PH (SOB, dizziness, fainting)		
<input type="checkbox"/> Patient has a confirmed pulmonary hypertension diagnosis		
<input type="checkbox"/> Patient is well-controlled on blood thinners and/or calcium channel blockers		
<input type="checkbox"/> Patient is on stronger medications (not including oxygen)		
<input type="checkbox"/> Patient is on oxygen: _____ liters		
<input type="checkbox"/> Patient has or needs a lung transplant		
Asthma	Yes	No
<input type="checkbox"/> Intermittent mild symptoms, no medication		
<input type="checkbox"/> Symptoms controlled with oral inhaler		
<input type="checkbox"/> Well-controlled with ongoing daily medication		
<input type="checkbox"/> Symptoms not well-controlled; patient using steroids or anticholinergics		
<input type="checkbox"/> Hospitalized within the last 2 years; history of intubation		
<input type="checkbox"/> Ever hospitalized for asthma		
GERD	Yes	No
<input type="checkbox"/> Intermittent or variable symptoms; no medication		
<input type="checkbox"/> Intermittent medication		
<input type="checkbox"/> H2 blockers or over-the-counter antacids (Zantac, Pepcid, Tagamet)		
<input type="checkbox"/> High-dose Proton Pump Inhibitor (Prevacid, Protonix, Nexuim, Prilosec)		
<input type="checkbox"/> Has been tested for GERD, has had pH probe or esophageal manometry, meets criteria for anti-reflux surgery, or has had prior surgery for GERD		
<input type="checkbox"/> History of Nissen Fundoplication		
<input type="checkbox"/> History of endoscopic plicator or stretta		
<input type="checkbox"/> Barrett's esophagus		

## Respiratory Disease continued

Cholelithiasis (Gallstones)	Yes	No
<input type="checkbox"/> Gallstones with no symptoms		
<input type="checkbox"/> Gallstones with intermittent symptoms		
<input type="checkbox"/> Gallstones with severe symptoms		
<input type="checkbox"/> Gallstones with complications requiring immediate surgery prior to gastric bypass		
<input type="checkbox"/> History of cholecystectomy (gallbladder removal)		

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- laparoscopic
- open
- History of cholecystectomy with ongoing complications not resolved

- |   |     |    |  |
|---|-----|----|--|
| Abdominal Hernia  | Yes | No |  |
| <input type="checkbox"/> No hernia  |     |    |  |
| <input type="checkbox"/> Asymptomatic hernia, no prior operation  |     |    |  |
| <input type="checkbox"/> Symptomatic hernia with or without incarceration   |     |    |  |
| <input type="checkbox"/> Successful repair  |     |    |  |
| <input type="checkbox"/> Recurrent hernia or size > 15 cm   |     |    |  |
| <input type="checkbox"/> Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs |     |    |  |

- |  |     |    |  |
|--|-----|----|--|
| Other G.I. Problems                                      | Yes | No |  |
| <input type="checkbox"/> Rectal bleeding                 |     |    |  |
| <input type="checkbox"/> Changes in bowel movements      |     |    |  |
| <input type="checkbox"/> Blood in stool                  |     |    |  |
| <input type="checkbox"/> Diarrhea                        |     |    |  |
| <input type="checkbox"/> Constipation                    |     |    |  |
| <input type="checkbox"/> Hemorrhoids                     |     |    |  |
| <input type="checkbox"/> Date of last colonoscopy: _____ |     |    |  |

- |   |     |    |  |
|---|-----|----|--|
| Hiatal Hernia                                   | Yes | No |  |
| <input type="checkbox"/> Small hernia           |     |    |  |
| <input type="checkbox"/> Large hernia           |     |    |  |
| <input type="checkbox"/> Difficultly swallowing |     |    |  |

- |  |     |    |  |
|--|-----|----|--|
| Liver Disease  | Yes | No |  |
| <input type="checkbox"/> Modest liver enlargement, normal liver function tests, fatty change Category 1                  |     |    |  |
| <input type="checkbox"/> Modest or greater liver enlargement, elevated liver function test, fatty change Category 2      |     |    |  |
| <input type="checkbox"/> Moderate to marked liver enlargement, fatty change Category 3, mild inflammation, mild fibrosis |     |    |  |
| <input type="checkbox"/> Definite cirrhosis, NASH, liver dysfunction indicated by liver function test                    |     |    |  |
| <input type="checkbox"/> Liver failure, transplant indicated or done   |     |    |  |

## 4. Musculoskeletal Disease

- |   |     |    |  |
|---|-----|----|--|
| Back Pain   | Yes | No |  |
| <input type="checkbox"/> Intermittent symptoms not requiring medical treatment                                      |     |    |  |
| <input type="checkbox"/> Symptoms requiring non-prescription treatment  |     |    |  |
| <input type="checkbox"/> Degenerative changes or positive objective findings, symptoms requiring narcotic treatment |     |    |  |
| <input type="checkbox"/> Meets criteria for surgical intervention   |     |    |  |
| <input type="checkbox"/> Operation ineffective  |     |    |  |

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Joint Pain Yes    No  
Where?  Hips     Knees     Ankles  
 Pain with exercise  
 Non-narcotic pain medication required  
 Pain with daily activities  
 Surgical intervention required  
          (i.e., arthroscopy)  
 Awaiting or has received joint replacement  
          or other disability

Fibromyalgia Yes    No  
 Treatment with exercise  
 Treatment with non-narcotic medications  
 Treatment with narcotics  
 Surgical intervention done or recommended  
 Disabling; treatment not effective

Functional Status (please check one)  
 Able to walk 200 feet unassisted  
 Able to walk 200 feet with assistance device  
          (cane, walker)  
 Unable to walk 200 feet with assistance device  
 Unable to walk more than 10 feet with assistance  
 Bedridden

## 5. Genitourinary and Reproductive

Urine leakage when laughing, coughing, or sneezing Yes    No  
 Minimal and intermittent  
 Frequent but not severe  
 Daily occurrence, requires sanitary pad  
 Disabling  
 Operation ineffective

### Genitourinary and Reproductive continued

Menstrual Irregularities Yes    No  
 Irregular or infrequent periods  
 Abnormally heavy or long periods  
 No periods  
 Prior total abdominal hysterectomy

Other genitourinary problems (check all that apply)  
 Frequent urination  
 Burning or painful urination

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- Blood in urine
- Change in force of stream when urinating

## 6. Neurological

- |   |     |    |
|---|-----|----|
| Pseudotumor Cerebri   | Yes | No |
| <input type="checkbox"/> Headaches with dizziness, nausea, and/or behind the eyes                         |     |    |
| <input type="checkbox"/> Headaches and visual symptoms  |     |    |
| <input type="checkbox"/> Patient has had an MRI to confirm PTC and is well-controlled with oral diuretics |     |    |
| <input type="checkbox"/> Patient is well-controlled with stronger medications                             |     |    |
| <input type="checkbox"/> Patient has had or needs a surgical intervention (i.e., a shunt)                 |     |    |

### Other Neurological problems (check all that apply)

- Tremors
- Seizures or convulsions
- Stroke
- Paralysis
- Headaches
- Numbness or tingling sensation

## 7. Skin

- |   |     |    |
|---|-----|----|
| Abdominal skin or pannus  | Yes | No |
| <input type="checkbox"/> Rash in skin folds   |     |    |
| <input type="checkbox"/> Abdominal skin that interferes with walking                      |     |    |
| <input type="checkbox"/> Recurrent cellulites and skin ulcers                             |     |    |
| <input type="checkbox"/> Presence of flesh-eating bacteria or surgical treatment required |     |    |
| <input type="checkbox"/> Skin tags  |     |    |
| <input type="checkbox"/> Skin discoloration in skin folds                                 |     |    |

## 8. Hematologic/Lymphatic

### Hematologic and Lymphatic Issues (check all that apply)

- Slow to heal cuts; bruising
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands
- Bleeding problem other than menses

## 9. Psychiatric

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Confirmed mental health diagnosis (check all that apply)

- Presently seeing a mental health professional
- Memory loss or confusion
- Suicidal tendencies
- Nervousness
- Insomnia
- Schizophrenia
- Bipolar disorder
- Depression
- Anxiety/panic disorder
- Personality disorder
- Psychosis
- Other: \_\_\_\_\_
- Hospitalized for mental illness

- | Depression   | Yes | No |
|--|-----|----|
| <input type="checkbox"/> Mild  |     |    |
| <input type="checkbox"/> Moderate, accompanied by some impairment, may require treatment |     |    |
| <input type="checkbox"/> Moderate with significant impairment, treatment indicated       |     |    |
| <input type="checkbox"/> Severe, definitely requiring intensive treatment                |     |    |
| <input type="checkbox"/> Severe, requiring hospitalization                               |     |    |

Psychosocial Impairment (check one)

- No impairment
- Mild impairment in psychosocial functioning but able to perform all primary tasks
- Moderate impairment in psychosocial functioning but able to perform most primary tasks
- Moderate impairment in psychosocial functioning and unable to perform most primary tasks
- Severe impairment in psychosocial functioning and unable to perform most primary tasks
- Severe impairment in psychosocial functioning and unable to function

## **Nutrition Evaluation:**

1. Present Weight: \_\_\_\_\_ Height (no shoes): \_\_\_\_\_ Desired Weight: \_\_\_\_\_
2. In what time frame would you like to be at your desired weight? \_\_\_\_\_
3. Birth Weight: \_\_\_\_\_ Weight at 18 years of age: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_
4. What is the main reason for your decision to lose weight? \_\_\_\_\_  
\_\_\_\_\_
5. When did you begin gaining excess weight? (Give reasons, if known): \_\_\_\_\_  
\_\_\_\_\_

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6. What has been your maximum lifetime weight (non-pregnant) and when? \_\_\_\_\_

7. Have you followed any previous diets?      Yes      No  
 If Yes, please check all that apply

<u>Weight Loss Methods</u> <u>Attempted:</u>	<u>Supervised by</u> <u>Professional:</u>	<u>Sustained Over</u> <u>Six Months:</u>	<u>Attempted Within</u> <u>Last Two Years:</u>
<input type="checkbox"/> None	_____	_____	_____
<input type="checkbox"/> Exercise Program(s)	_____	_____	_____
<input type="checkbox"/> Behavioral Modification	_____	_____	_____
<input type="checkbox"/> Medication for weight loss	_____	_____	_____
Please list:			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<input type="checkbox"/> Commercial Programs	_____	_____	_____
<input type="checkbox"/> Weight Watchers	_____	_____	_____
<input type="checkbox"/> Jenny Craig	_____	_____	_____
<input type="checkbox"/> Optifast	_____	_____	_____
<input type="checkbox"/> Nutrisystem	_____	_____	_____
<input type="checkbox"/> Atkins	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Self-created diet	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

8. How often do you eat out? \_\_\_\_\_

9. What restaurants do you frequent? \_\_\_\_\_

10. How often do you eat "fast foods?" \_\_\_\_\_

11. Who plans meals? \_\_\_\_\_ Cooks? \_\_\_\_\_ Shops? \_\_\_\_\_

12. Do you use a shopping list?      Yes      No

13. What time of day and on what day do you usually shop for groceries? \_\_\_\_\_

14. Food allergies: \_\_\_\_\_

\_\_\_\_\_

15. Food dislikes: \_\_\_\_\_

\_\_\_\_\_

16. Food(s) you crave: \_\_\_\_\_

\_\_\_\_\_

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17. Any specific time of the day or month you crave food? \_\_\_\_\_

18. Do you drink coffee or tea? Yes No How much daily? \_\_\_\_\_

19. Do you drink cola drinks? Yes No How much daily? \_\_\_\_\_

23. Do you use a sugar substitute? Yes No If yes, what? \_\_\_\_\_

Butter? Yes No If yes, what? \_\_\_\_\_

Margarine? Yes No If yes, what? \_\_\_\_\_

24. Do you awaken hungry during the night? Yes No

What do you do? \_\_\_\_\_

25. What are your worst food habits? \_\_\_\_\_

26. Snack Habits:

What?	How much?	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

30. Typical Breakfast Typical Lunch Typical Dinner

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Time eaten: \_\_\_\_\_ Time eaten: \_\_\_\_\_ Time eaten: \_\_\_\_\_

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Where: \_\_\_\_\_

Where: \_\_\_\_\_

Where: \_\_\_\_\_

With whom: \_\_\_\_\_

With whom: \_\_\_\_\_

With whom: \_\_\_\_\_

31. Describe your usual energy level: \_\_\_\_\_  
\_\_\_\_\_

32. Activity Level: **(answer only one)**

- Inactive—no regular physical activity with a sit-down job.
- Light activity—no organized physical activity during leisure time.
- Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
- Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: **(answer only one)**

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. Personal Goals: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

36. Why do you want to lose weight? \_\_\_\_\_

## **ACTION Weight Management Centers**

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This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.