PATIENT WEIGHT LOSS AND MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Weight: _____ Height: _____ Date of Birth: _____

Allergies to medications: _____

Primary care physician: _____

Primary care physician's office number: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

NAME	DOSAGE	FREQUENCY	INDICATIONS

PAST SURGICAL HISTORY: PLEASE LIST SURGICAL OPERATIONS

PROCEDURE	DATE	HOSPITAL	INDICATIONS

FAMILY HISTORY: PLEASE INDICATE FAMILY MEMBERS HAVING ANY OF THE FOLLOWING ILLNESSES

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	SIBLINGS
OBESITY							
DIABETES							
HIGH BLOOD PRESSURE							
HEART DISEASE							
CANCER							
SEIZURES							
BREATHING PROBLEMS							
KIDNEY DISEASE							
ARTHRITIS							
EARLY DEATH & CAUSE							
OTHER							

Patient name: _____

How many years have you been overweight? _____

PREVIOUS WEIGHT LOSS SURGERY? NO _____ YES _____

SURGERY TYPE	DATE	SURGEON	WEIGHT LOSS

DIET PROGRAMS AND SUPPLEMENTS: PLEASE INDICATE THE DIETS OR PLANS THAT APPLY

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutri/System				
Atkins Diet				
Herbalife				
Slim Fast				
Grapefruit Diet				
Liquid Diets				
Pritikin Diet				
Optifast				
TOPS				
Other				

WEIGHT LOSS MEDICATION HISTORY: PLEASE INDICATE THE MEDICATIONS THAT APPLY

MEDICATION	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexfenfluramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication				

NON DIETARY THERAPIES: PLEASE INDICATE THE WEIGHT LOSS THERAPIES THAT APPLY

THERAPY	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient name: _____