

MEDICAL HISTORY

Please (√) check any medical problems, current or past.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies (Environmental)
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Binge Eating Disorder
<input type="checkbox"/> Biopsies
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Constipation
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fainting/Dizzy Spells
<input type="checkbox"/> Fatty Liver
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gallbladder Disorder
<input type="checkbox"/> Gastritis/GERD (reflux) | <input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout
<input type="checkbox"/> Gum Disease
<input type="checkbox"/> Heart Attack/Disease
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Infertility
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Lactose Intolerance
<input type="checkbox"/> Liposuction
<input type="checkbox"/> Liver Disease (other than Hepatitis) | <input type="checkbox"/> Lung Disease (other than Emphysema)
<input type="checkbox"/> Migraines
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Poly Cystic Ovarian Syndrome
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Sinusitis (Frequent)
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Swelling Feet/Ankles
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Transient Ischemic Attack (TIA)
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers of Legs/Feet
<input type="checkbox"/> Valvular Heart Disease
<input type="checkbox"/> Vertigo |
|---|--|---|

Other Conditions: _____

Have you had serious accidents or injuries: Yes No If yes, please specify below.

Event: _____ Date: _____

Event: _____ Date: _____

Have you had surgery: Yes No If yes, please specify below.

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____



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Medications: Are you taking any medications (prescription or over-the counter), vitamins, mineral, or nutritional/herbal supplements at the present time? No Yes, please specify below

Example: Lasix

20mg

One every morning

Name of Medication	Strength	How Much/How Often

Please list any weight loss medications you have taken in the past.

_____ None

How often do you forget to take your medication? _____ Never

Do you have any allergies to any medications? No Yes, please list medications and reactions:

MENTAL HEALTH HISTORY: Please check any mental health problems, current or past which you have been diagnosed.

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Binge Eating | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Panic Attacks | |

Was there ever a time in your life when you were sexually, physically, or mentally abused? Yes No

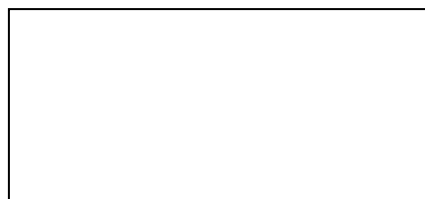
If yes, please circle which one. If yes, have you ever received counseling for this? Yes No

Have you ever been hospitalized for a psychiatric illness? Yes No If yes, please explain.

What are your main worries now? _____



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FAMILY HISTORY

Please (√) check any medical problems, current or past.

Family History					
Condition	Mother	Father	Children	Siblings	Grandparents
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morbid Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot – Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot – Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other</i>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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REVIEW OF SYSTEMS: Please carefully review the following symptoms listed below. If you have EVER had any of the symptoms, please respond in the appropriate YES box. Space is provided for you to comment on or explain any condition. Add additional pages if necessary.

1) HEAD/NECK

- | | | YES | YES |
|-------------------------------|-------|--------------------------|--------------------------|
| | | Still a problem | No longer a problem |
| A. Unrelieved dental/gum pain | | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Headaches | | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Neck swelling/lumps | | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Unusual change in vision | | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Sinus pain/pressure | | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Nosebleeds | | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Extreme snoring | | <input type="checkbox"/> | <input type="checkbox"/> |

2) RESPIRATORY

- | | | | |
|---|-------|--------------------------|--------------------------|
| A. Unusual shortness of breath | | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Persistent cough | | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Pain with breathing | | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Wheezing | | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Coughing up blood | | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Waking up short of breath at night | | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Having to sit up at night to breathe | | <input type="checkbox"/> | <input type="checkbox"/> |

3) CARDIOVASCULAR

- | | | | |
|--|-------|--------------------------|--------------------------|
| A. Irregular heartbeats (palpitations) | | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Racing heartbeats | | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Racing heartbeats relieved with a maneuver (ie coughing) | | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Chest discomfort/pressure/tightness | | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any discomfort/pressure/tightness in the chest, shoulders, arms, back, throat, or jaw with exertion | | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Leg/ankle swelling | | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Blood clots | | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Non-healing leg/foot ulcers | | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Cramps in legs/calves | | | |
| 1. When walking | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. at night | | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Discoloration of extremities (fingers, toes) in cold exposure | | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Varicose veins | | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Temporary loss of vision, loss of movement, Numbness, facial droop ("mini-stroke") | | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Lightheadedness with standing/exertion | | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Unusual dizziness/spinning sensations | | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Fainting spells | | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Easy bruising or bleeding | | <input type="checkbox"/> | <input type="checkbox"/> |

4) MUSCULOSKELETAL

- | | | | |
|-------------------------------------|-------|--------------------------|--------------------------|
| A. Low back pain | | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Generalized back pain (all over) | | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Joint swelling | | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Knee pain | | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Hip pain | | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Neck pain | | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Muscle aches | | <input type="checkbox"/> | <input type="checkbox"/> |



5) ENDOCRINE

- A. Heat intolerance
- B. Cold intolerance
- C. Hot flashes
- D. Unusual hair growth or loss of hair
- E. Shakiness/jitteriness
- F. Excessively dry skin
- G. Loss of sexual drive
- H. Change in voice (has become lower)

6) DIGESTIVE

- A. Persistent nausea
- B. Unusual vomiting
- C. Acid indigestion/reflux/heartburn
- D. Frequent episodes of diarrhea
- E. Frequent constipation
- F. Black tarry stools
- G. Rectal bleeding
- H. Bowel cramps
- I. Abdominal pain after eating
- J. Pain in right upper abdomen just after eating a fatty meal
(i.e.: French fries, pizza, fried chicken)

7) GENITOURINARY

- A. Blood in urine
- B. Difficulty with sexual function/performance
- C. Impotence
- D. Frequent urination
- E. Excessive nighttime urination (more than 2 times)

8) NEUROLOGIC

- B. Unexplained loss of consciousness
- C. Loss of feeling in any part of your body
- D. Persistent tingling in any part of your body
- E. Weakness in any part of your body
- F. Unexplained seizing or convulsing
- G. Persistent headaches on the same side of head;
worse in the morning.
- H. Numbness or burning in feet



WEIGHT HISTORY

Your weight history and family weight history can provide information to help understand the possible causes of your weight issues and help set reasonable expectations for weight management.

Ideally, what would you like to weigh now? _____ How did you choose that weight? _____	
What was your highest weight after age 21 (excluding pregnancy)? _____ pounds at _____ years old.	
What has been your lowest weight (not attributable to illness) in the past 5 years? _____ 1 year? _____	
At what age were you first overweight by 15 pounds or more (excluding pregnancy)? _ years old ____ don't know	
Are you a yo-yo dieter (do you intentionally lose weight and then regain the weight often)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How much did your weight fluctuate in a typical period during the last ten years? _____	
If you have successfully lost more than 15 pounds in the past, how did you do it? _____	____ Not Applicable
Do you have a history of Bulimia Nervosa (bingeing and purging) or Anorexia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NUTRITION HISTORY

How many times each week do you eat away from home? _____ <ul style="list-style-type: none"> • Which meals are usually eaten away from home? _____ Where? _____	
Do you drink alcohol? <ul style="list-style-type: none"> • Type: _____ How often: _____ How much: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you lactose intolerant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take vitamins, minerals, herbs, or any other food or nutritional supplement? If yes, please list: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
What do you snack on? _____	
Do you skip meals often? If yes, list which meals you skip most often and why: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
What time of the day are you most hungry? _____ What do you think when you are thirsty? _____	
Are your eating habits different on days off or weekends? If so, how? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No



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PHYSICAL ACTIVITY

Regular physical activity is associated with long-term weight control success. In this section, please tell about your current physical activity and exercise habits that you perform regularly.

1. Please consider your physical activity over the last month. Estimate as accurately as possible the total amount of time that you typically spent each day doing activities of various levels. Examples are listed. Estimate time in quarter hours (15-minute periods): total hours for the day should equal 24.

	Weekdays	Weekend Days
A. Sleeping, napping, lying down	hrs	hrs
B. Sitting, reading, desk work, watching television	hrs	hrs
C. Standing (little movement), grooming, cooking, light housework	hrs	hrs
D. Standing (moderate movement), strolling, shopping, lifting, or carrying light objects	hrs	hrs
E. Brisk walking (3-4 mph), moving digging, golf, social dancing, doubles tennis, sweeping, vacuuming or similar activity	hrs	hrs
F. Running, jogging, singles tennis, cycling, physical labor or similar activity	hrs	hrs

2. What is your usual pace of walking?
- Casual or strolling (less than 2 mph) Average or normal (2 to 3 mph)
 Fairly brisk (3 to 4 mph) Brisk or striding (4 mph or faster)
3. How many times per WEEK do you engage in vigorous physical activity long enough to work up a sweat? _____ times per week
4. How much time could you realistically have to exercise per week?
- 30 minutes daily 30 minutes three times a week
 45 minutes three times a week 45 minutes five times a week
 60 minutes five times a week Other _____
5. What are your favorite hobbies? _____
6. Have you had enjoyment with exercise in the past? No If yes, what type?

7. Do you have a history of falls or balance problems? No Yes, - if yes, what type of assistance is needed?

Action plan: _____



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