

■ ■ Weight Loss Institute of New Jersey

Monmouth Medical Center

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Patient Questionnaire

Please fill out the form below and bring it with you to your consult. Thank you !

Patient Information:

First name: _____ Last name: _____ Middle initial: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Business phone: _____ Cell phone: _____

Social security number: _____ D.O.B.: _____ E Mail: _____

Marital status: M S W D Sex: M F Age: _____ Height: _____ Weight: _____

Employer: _____ Occupation: _____

Employer address: _____ City _____ State: _____ Zip code: _____

E-mail address: _____

Name of Primary Care Physician: _____

Phone number: _____ Fax number: _____

Spouse Information:

Spouse's name: _____ Business phone: _____

Who referred you to our office? _____

Primary physician's name: _____ Phone number: _____

Address: _____

Social History:

Do you smoke now? _____yes _____no

If yes, how much? _____

For how many years have/did you use tobacco? _____

If you have quit, how long ago? _____yes _____no

Do you consume alcohol now? _____yes _____no

If yes, how many times a week? _____

How many drinks each time? _____

For how many years do/did you drink alcohol? _____

If you have quit, how long ago? _____

Do you drink coffee or other caffeine-containing beverages? __yes __no

If yes, how many cups per day? _____

Do you drink carbonated beverages? _____

If yes, how many cans per day? _____

On a scale of 1 to 5 (1=least satisfied 5=very satisfied), rate the following situations in your life.

Married life? _____

Present job? _____

Overall satisfaction with yourself? _____

What hobbies do you have that are important to you?

If you are disabled, is it due to? __Physical ailments __Mental ailments

Do you have children? __yes __no

How many? _____

Why do you eat?

__Physical hunger __Loneliness

__Anxiousness __Makes me happy

__Bored __ Other

What reasons do you feel contribute to you being overweight?

__Inactivity __Emotional wellbeing

__Over Consumption

What is motivating you to seek this type of intervention for weight loss?

Medical History:

Do you have or have you ever had any of the following:

Allergies to medications or foods:

__ Yes __ No

If yes, to which medications and what kind of reaction did you have:

General:

__ Cancer __ High cholesterol
__ Fatigue __ High triglycerides
__ Non alcoholic fatty liver __ Pancreatitis

If yes, since when and form of treatment (list medications prescribed):

Head and neck:

- | | |
|---|--|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Difficulty swallowing |

If yes, since when and form of treatment (list medications prescribed):

Cardiovascular:

- | | |
|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Stroke/ TIA | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Pain in legs | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Loss of pulses | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abnormal heart beats |
| <input type="checkbox"/> Coronary bypass surgery | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Venous insufficiency |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Other |

If yes, since when and form of treatment (list medications prescribed):

Respiratory:

- | | |
|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Observed apnea spells |
| <input type="checkbox"/> Use of CPAP/BiPAP | <input type="checkbox"/> Awakening at night |

If yes, since when and form of treatment (list medications prescribed):

Gastrointestinal:

- | | |
|---|--|
| <input type="checkbox"/> Gastro-esophageal reflux | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Gallbladder disease |

If yes, since when and form of treatment (list medications prescribed):

Genitourinary:

- | | |
|--|--|
| <input type="checkbox"/> Kidney stones/ kidney disease | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Leaking urine with coughing/ sneezing |

If yes, since when and form of treatment (list medications prescribed):

Musculoskeletal:

- | | |
|---|---|
| <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot and/or ankle pain |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Foot swelling |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Numbness in feet or legs |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle aches |

If yes, since when and form of treatment (list medications prescribed)

Endocrine:

- | | |
|--|---|
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Previous thyroid radiation |
| <input type="checkbox"/> Juvenile diabetes | <input type="checkbox"/> Adult onset diabetes |
| <input type="checkbox"/> Oral medications for diabetes | <input type="checkbox"/> Insulin |

If yes, since when and form of treatment (list medications prescribed)

Neurological:

- | | |
|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Falling |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Limb numbness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Light headness |

If yes, since when and form of treatment (list medications prescribed)

Psychological:

- Depression
- Anxiety
- Nervousness
- Suicidal thoughts

If yes, since when and form of treatment (list medications prescribed)

Women:

- Difficulty achieving pregnancy
- Ovarian cysts
- Irregular periods
- Cessation of periods
- Fibroids/ tumors in uterus
- Painful periods
- Heavy periods
- Post menopausal

If yes, since when and form of treatment (list medications prescribed)

Surgical History

Have you had any operations? Yes No

If yes, list the year it was done, and the hospital where it was done

Did you have general anesthesia? Yes No

If yes, did you have any problems? Yes No

If yes, what kind of problems did you experience?

Family Medical History

- Obesity
- Stroke
- High blood pressure
- Heart disease
- Diabetes
- Other...

If any of the above are checked, please check the family members who have medical problems and specify the problem. If the family member is deceased, please specify the cause of death and age of death, if known:

Mother _____

Father _____

Maternal grandmother _____

Paternal grandmother _____

Maternal grandfather _____

Paternal grandfather _____

Brother/sister _____

Children _____

Children _____

Children _____

If you have attempted to lose weight in the past, please answer the following questions:

Since when have you been overweight? _____

When you lose weight, do you always regain it? _____

Do you usually gain back more than you lose? _____

What was your lowest adult weight? _____

What was your highest adult weight? _____

What was the biggest loss in pounds you had and how long did it take to regain weight?

Do you feel that your weight affects your life? Yes No

If yes, please explain

Patient signature: _____ **Date:** _____