DERBY  DERM

Medical Weight Loss Patient Information

Have you had any of these health problems in the past or present? (circle all that apply)

Bronchitis	Cancer	Constipation/Diarrhea	Dizzy Spells
Drug Abuse	Eating Disorder	Fainting Spells	Fatigue
Frequent Urination	Gallbladder Disorder	Glaucoma	Headaches
Insomnia	Moodiness	Nervousness/Anxiety	Obesity
Heart Palpitations	Rashes		

Do you have any surgeries planned in the near future? If so, please describe below:

_____

_____

Health Habits:

Exercise: (Please circle answer)	Sedentary Occasional high intensity exercise (i.e. sports, running/jogging 1-3 times/week) Mild Exercise (i.e. walking, golf) Regular high intensity exercise (i.e. sports, running/jogging 4+ times/week)
Diet: (Please circle best answer)	Are you currently on a diet? **Yes** **No** If so, is it medically supervised? **Yes** **No** How many times do you eat a day? _____meals _____snacks How much water do you drink a day? _____glasses/cups/liters
Caffeine: Please circle answer)	Do you drink caffeinated beverages? **Yes** **No** What types of caffeine do you drink? **Soda** **Tea** **Coffee** **Other**_____ How many cans/cups per day? _____cups/cans
Drugs:	Are you currently using illicit drugs? **Yes** **No** Have you used illicit drugs in the past? **Yes** **No** If so, please list type and years used:_____ _____
Women only:	Are you pregnant? **Yes** **No** Are you trying to get pregnant? **Yes** **No** Are you breastfeeding? **Yes** **No** If you are not trying to get pregnant, what method of birth control are you using? _____ How old were you at the onset of menstruation? _____years old Date of last menstruation _____ How often do you get your period (days)?_____ Are your periods… **Heavy** **Irregular** **Painful**

Weight History:

1.) What made you decide that you wanted to lose weight?

2.) When did you start to become overweight?

3.) What do you attribute your weight gain to?

4.) What other ways have you attempted to lose weight? What are the reasons that you think these attempts didn't work for you?

5.) Is your spouse or significant other overweight?

6.) Do you feel that the people that you live and work with would support your efforts to lose weight?

7.) Do you have any food allergies?

8.) What foods do you avoid?

9.) What foods do you crave?

10.) What are your worst food habits?

11.) What do you feel are your biggest challenges when it comes to weight loss?

12.) Do you eat breakfast? If so, what do you typically eat?

13.) What time do you eat lunch? What do you typically eat?

14.) What time do you eat dinner? What do you typically eat?

15.) Do you like to exercise? Do you play sports or are there any activities such as gardening or walking the dog that you enjoy?

16.) Please add any additional comments that you think would be helpful in creating a weight loss plan that works best for you.