WEIGHT MANAGEMENT
INSTITUTE •of• GEORGIA

New Weight Loss Medical History Form

Please answer all questions *completely* *before* your first office visit. If your form is not completely filled out before your appointment you will be rescheduled.

Name: ___________________________ Age: ______ Date of birth: __________ Sex: M F

Present Status:

1. Who is your Primary Care Physician? ____

Address: ____ Office #_____________

2. Are you taking any medications at the present time? Yes No

Prescription Drugs:

(Please list **all medications**, including any "as needed" medications and birth control medicines)

Drug: Dosage: Frequency: (as needed, 2x/day, etc)

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____

Over-the-Counter medications, vitamins, supplements: Yes No

Product: Dosage: Frequency:

3. Please list all Current Medical Problems:

4. Are you allergic to any medications? Yes No

Please list:

Past Medical History:

Please check if you have EVER had or CURRENTLY have any of the following medical problems:

_______Diabetes
_______Fatty Liver
_______Kidney Disease
_______Heartburn/GERD
_______Rheumatic Fever
_______Stomach Ulcers
_______Anemia
_______Infertility
_______Back Pain
_______Hip Pain
_______Knee Pain
_______Arthritis
________ Heart palpitations
________ Sleep Apnea
________ Stroke
________ Swelling in feet/legs

_______Erectile Dysfunction
_______High Cholesterol
_______Hypertension
_______Irregular Periods
_______Bleeding Disorder
_______Gout
_______Heart Valve Disorder
_______Gallbladder Disorder
_______Eating Disorder
_______Pre-Diabetes
_______Cancer
_______Osteoporosis
________ Shortness of Breath
________ Snoring
________ Fibromyalgia
________Vitamin D deficiency

_______Cushing's Disease
_______COPD/Emphysema
_______Liver Disease
_______Fatigue
_______Depression
_______Thyroid Disease
_______Heart Disease
_______Anxiety
_______Alcohol Abuse
_______Drug Use
_______Plantar fasciitis
_______Headaches
_______ Glaucoma
________Heart Attack
________ADD/ADHD
________ Chronic Fatigue Syndrome

________ Other____

________ Other____

________ Other____

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: ____

Hormone Replacement Therapy: Yes No

What: ____

Birth Control Pills: Yes No

Type: ____

Surgical History:

Any Surgery?Yes No

Specify: (List all) Date

____

____

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Family History:

Age HealthDisease Cause of Death Overweight?

Father: ____

Mother: ____

Brothers: ____

Sisters: ____

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: ________________________________

Asthma: Yes No Who: ________________________________

Epilepsy: Yes No Who: ________________________________

High Blood PressureYes No Who: ________________________________

Kidney Disease: Yes No Who: ________________________________

Diabetes: Yes No Who: ________________________________

Psychiatric Disorder Yes No Who: ________________________________

Heart Disease/Stroke Yes No Who: ________________________________

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 20 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):
   ____
   ____
6. What has been your maximum lifetime weight (non-pregnant) and when?________________
7. Previous diets you have followed: Give dates and results of your weight loss:

____
____
____
____
____
____

8. What do you do for a living?____
9. Describe your work schedule.____
10. Is your spouse, fiancee or partner overweight? Yes No
11. By how much is he or she overweight? ____
12. Are your children overweight? Yes No
13. How often do you eat out? ____
14. What restaurants do you frequent?____
15. How often do you eat "fast foods?"____
16. Who plans meals? ________________________ Cooks? _________________ Shops? _____
17. Do you use a shopping list? Yes No
18. What time of day and on what day do you usually shop for groceries? __________________

19. Food allergies: ____

20. Food dislikes: ____

21. Food(s) you crave:____

22. Any specific time of the day or month do you crave food? ___________________________

23. Do you drink coffee or tea? Yes No How much daily? ______________________

24. Do you drink cola drinks? Yes No How much daily? ________________________

25. Do you drink alcohol? Yes No

What? ____________________ How much daily? _________ Weekly? _______________

26. Do you use a sugar substitute? ______ Butter? ___________ Margarine? _____________

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

What do you do? ____

28. What are your worst food habits? ____

29. Snack Habits: Give examples of foods you frequently snack on, and when.

____

____

____

30. Have you ever been diagnosed or treated by a medical professional for eating disorders such as Anorexia, Bulimia, Binge Easting Disorder? YES NO If yes, please explain:

____

____

____

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

____

____

____

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

____

____

____

33. Please describe an average day of eating (This part MUST be filled out!)

Typical Breakfast: What time of day?______ Do you usually eat at home / work / restaurant?

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____
____
____
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____

Typical Lunch: What time of day?_________ Do you usually eat at home / work / restaurant?

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Typical Dinner: What time of day?_________ Do you usually eat at home / work / restaurant?

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____

34. Describe your usual energy level: ____

35. 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.
___Other ____

36. Do you become short of breath easily with exercise? YES NO

Has this worsened recently?____

37. Smoking Habits: **(answer only one)**

___You have never smoked 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).
___ You smoke more than 2 packs per day
___ Other ____

38. Please describe your general health goals and improvements you wish to make:
____
____
____
____

Please Sign and Date this form below

Patient Signature_______________________________________ Date________________

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.

For Office Use Only
This patient history has been reviewed and modified by myself.

Physician Signature___________________________________ Date ____________
____

Welcome to the Weight Management Institute of Georgia!

Here are some helpful tips to make your weight loss visits more productive.

*If you are diabetic, bring in your blood sugar log or meter to each visit. Even though your PCP or Endocrinologist is following your diabetes, it is very useful for me know all of your blood sugar readings, as that can help me adjust your eating plan and medication options to maximize your health and weight loss.

*If you are keeping a food journal on paper, make sure to total up the calories at the end of each day. Especially if you are just starting to journal, bring your journal in to each of your appointments so I can review what you have been eating.

*Each visit my nurse will ask you what percentage of the time you are following your eating plan EXACTLY. Try to plan ahead and think of what that percentage would be.

*Try to schedule your follow up appointment at a time you know you will be able to come in. You can reschedule your appointment if needed, but we tend to be booked very heavily for two weeks in advance and odds are you won't be able to be seen for another week or two after rescheduling. Studies show going longer than 2 weeks in between appointments slows weight loss efforts significantly.

*If you need to reschedule an appointment, please give us at least 24 hours notice, so we can try to give patients who are on the waiting list that appointment slot. Our policy is to bill you for your visit (not just your co-pay) if you do not show for your appointment or if you cancel less than 24 hours before your appointment time. We really do not want to charge you! Give us a call if you have a true emergency and we will see what we can do to avoid this charge.

*Do not schedule an appointment with a Georgia Lung doctor on the same day you see us. Your insurance won't like this and will end up **not** paying for one of the visits, leaving you with a big bill! You can avoid this just by scheduling your appointments downstairs on a separate day. Seeing Physical Therapy on the same day is OK, though.

*Plan to do your grocery shopping AFTER your follow up visits, just in case we change around your eating plan.

*Make sure to let our nurse know if any medicines have changed, including dose changes.

*If you have labs done with another physician, ask them for a copy and bring it into our next appointment, so we can update our charts as well.

We hope these tips help. Please feel free to call our office if you have any questions, or feel free to visit our new website www.wmiga.com

Current Health Provider List

We need a list of all of your current healthcare providers. If you have seen them in the last year, please include them in the list. This includes Physician Assistants and Nurse Practitioners.

Primary Care Provider (Family Practice, Internal Medicine, Pediatrician, etc)

Name:____

Phone:____

Office Address:____

Other Physicians:

Name:____

Specialty:______________________________Phone:_____________________________________

Other Physicians:

Name:____

Specialty:______________________________Phone:_____________________________________

Other Physicians:

Name:____

Specialty:______________________________Phone:_____________________________________

Other Physicians:

Name:____

Specialty:______________________________Phone:_____________________________________

Other Physicians:

Name:____

Specialty:______________________________Phone:_____________________________________