Weight Loss Questionnaire

Patient's Name: _____ Today's Date: _____

Have you ever had any of the following:

	Yes	No		Yes	No
Heart Attack/Heart Disease			Heart arrhythmia/Afib		
High Blood Pressure			Thyroid Issues		
Currently pregnant or breastfeeding?			Bariatric surgery		
Diabetes			Glaucoma		
High Cholesterol			Epilepsy/Seizures		
Anxiety/Depression/Bipolar (circle)			Eating Disorder		
Kidney disease, kidney stones			Pancreatitis		
Do you smoke?			Liver Disease		
Do you drink alcohol?			Cancer (type:_____)		

What is your goal weight? _____ lbs
Your statement of present health is ____ Excellent ____ Good ____ Fair/Poor
Pharmacy: _____
Drug Allergies: _____
Last Menstrual period: _____
Surgeries: _____

Have you ever been on a weight loss program before? _____
If yes, please explain: _____

Are you interested in short term (3 months or less) or long term weight loss medication? _____
Is there a particular weight loss medication you are interested in? _____

Do you Exercise? _____ How Often _____

Who is your Primary Care Provider? _____
Have you had any labs drawn within the last 3 months? _____

Do you take any medications? _____
List all of your Medications: _____
_____

Do you take any supplements? _____
List all of your supplements _____
_____

Please list any additional information you think our provider should know: _____
_____
_____