WEIGHT MANAGEMENT MEDICINE
PATIENT HISTORY QUESTIONNAIRE

PALOMAR HEALTH Medical Group

*The information requested below is very important. To give you the best care, we must have complete and **honest** answers. Please be thorough and print clearly with black ink. Thank you.*

Patient Name: _____ Date of Birth: _____

Please record current home values below. If you do not have a BP cuff, use your last recorded vitals

HEIGHT (feet/inches)	WEIGHT (pounds)	BLOOD PRESSURE	HEART RATE

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Events	Age	Weight
Child obesity		
High School Graduation		
College years		
Marriage		
Lowest weight in past 5 years		
Highest weight in past 5 years		
Weight one year ago		
Other:		
Other:		
Other:		

What is your Goal Weight? _____

Do you use a home scale? ☐Yes ☐No How often do you weight yourself? _____

Have you had bariatric surgery? ☐Yes ☐No

If No, are you interested in learning more about bariatric/weight loss surgery? ☐Yes ☐No

If Yes, which procedure and when: ☐LapBand ☐Gastric ByPass ☐Gastric Sleeve Date: _____

What is motivating you to seek this type of intervention for weight control and/or loss?

_____

SOCIAL HISTORY:

1. Do you use any tobacco? ☐Yes ☐No Do you vape? ☐Yes ☐No
   a. If yes – what? _____
   b. How often/much? _____
2. Do you drink alcohol? ☐Yes ☐No
   a. If yes – what kind/how much/often? _____
3. Any drug use? ☐Yes ☐No
   a. If yes – type/how much/often? _____
4. History of drug overdose? ☐Yes ☐No
   a. If yes – when? _____

FAMILY HISTORY:

Is there Obesity in the family? ☐Yes ☐No If yes, please list: _____

_____

Are there any medical illnesses in your immediate family? ☐Yes ☐No If yes, what/who:

Diabetes? ☐Yes ☐No Who: _____

Hypertension? ☐Yes ☐No Who: _____

Coronary Artery Disease? ☐Yes ☐No Who: _____

Cancer? ☐Yes ☐No Type: _____ Who: _____

Other: _____ _____

WEIGHT LOSS ATTEMPT HISTORY:

Please list ALL weight loss attempts, physician-supervised programs as well as self-monitored diets. Please take the time to be as thorough as possible.

Age you first started dieting: _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ACUPUNCTURE						☐Yes ☐No
ALLI						☐Yes ☐No
ATKINS						☐Yes ☐No
KETO-DIET						☐Yes ☐No
Calorie Counting						☐Yes ☐No
FEN/PHEN or REDUX						☐Yes ☐No
JENNY CRAIG						☐Yes ☐No
MERIDIA						☐Yes ☐No
METABOLIFE						☐Yes ☐No
NUTRI-SYSTEMS						☐Yes ☐No
OPTI-FAST or MEDI FAST						☐Yes ☐No
OVER THE COUNTER DIET AIDS						☐Yes ☐No
RICHARD SIMMONS						☐Yes ☐No
SOUTH BEACH DIET						☐Yes ☐No
T.O.P.S.						☐Yes ☐No
WEIGHT WATCHERS						☐Yes ☐No
XENICAL						☐Yes ☐No
Any Rx med for weight loss? Rx Name(s):						☐Yes ☐No
Other Prescription/Shots						☐Yes ☐No
Other bariatric program? Which Surgeon?						☐Yes ☐No
Any support groups?						☐Yes ☐No

List any other physician-supervised and documented weight loss attempt:

_____

_____

FOOD INTAKE:

What specific Food Plan/Diet are you currently following, if any? _____

How many meals do you consume per day? _____

Do you skip meals? ☐Yes ☐No Number of snacks per day? _____

Do you eat breakfast? ☐Yes ☐No

How late is your dinner? _____ When is your typical bedtime? ____ Do you snack after dinner? ___

Do you snack between meals? ☐Yes ☐No

If so, what? _____

How often? _____

Is snacking from habit? ☐Yes ☐No Depression? ☐Yes ☐No

Boredom? ☐Yes ☐No Do you binge eat? ☐Yes ☐No

If so, what? _____

How often? _____

Do you have any eating related problems or concerns? ☐Yes ☐No If yes, please explain: _____

_____

Are you willing to cook or prefer purchasing meals? _____

Do you feel deprived of any foods? ☐Yes ☐No

Do you feel restricted of any foods? ☐Yes ☐No

Any foods/beverages not tolerated? ☐Yes ☐No If so: _____

_____

Do you have any diet restrictions?

Vegan? ☐Yes ☐No

Vegetarian? ☐Yes ☐No

Lactose intolerant? ☐Yes ☐No

Gluten Free? ☐Yes ☐No

Other? _____

How many grams of protein do you get in daily? (best estimate) From drinks? _____

From food? _____

How much **WATER** do you drink in a 24-hour period? ☐24oz (3 cups or less) ☐32oz (4+ cups) ☐64oz (8+ cups) Other: _____

What do you drink other than water? _____ How much? _____

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	*Place*	*Food/beverage*	*Amount*
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

PHYSICAL ACTIVITY:
Do you exercise regularly? ☐Yes ☐No If yes, do you have an exercise regimen? Please list in table below.
Do you have any physical restrictions that keep you from exercising? If Yes, Explain? _____

Type of Physical Activity (Walking, Yoga, Cardio, Weights, Swim, etc)	Intensity (Light, medium or high)	Daily?	How often?	Comments
		☐Yes ☐No		
		☐Yes ☐No		

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following? Check all that apply.

Psychologic

1. Do you have any of the following? (Please check all that apply)
   a. ☐Depression ☐Panic attacks ☐Anxiety ☐Bipolar Disease ☐Obsessive Compulsive Disorder ☐Eating Disorder ☐other: _____
   b. Seeking treatment? ☐Yes ☐No
   c. Medications? ☐Yes ☐No Please list under medications
2. Do you have a history of suicide attempt or suicidal ideation? ☐Yes ☐No
   If so, when: _____
3. Are you currently seeing a psychologist/psychiatrist/therapist? ☐Yes ☐No.

Sleep Health

1. How many hours do you typically sleep per night? _____ hours
2. If you have insomnia, do you have trouble falling asleep or staying asleep? ☐Yes ☐No
3. Have you been told you stop breathing when sleeping? ☐Yes ☐No
4. Do you have excessive daytime sleepiness? ☐Yes ☐No
5. Have you been diagnosed with Sleep Apnea? ☐Yes ☐No
6. If yes, do you use a CPAP or oral device? ☐Yes ☐No

Cardiovascular

1. High blood pressure ☐Yes ☐No
2. If yes – medication? ☐Yes ☐No Please list under medications
3. Heart Attack? ☐Yes ☐No When? _____
4. Heart Bypass surgery? ☐Yes ☐No When? _____
5. Stents? ☐Yes ☐No When? _____
6. Pacemaker? ☐Yes ☐No When? _____

Endocrine

1. Diabetes? ☐Yes ☐No
2. If Yes, do you have Low Sugar Episodes?
3. If Yes, please write your current A1C blood test value if known? _____
4. If Yes – medication? ☐Yes ☐No Please list under medications
5. Thyroid problems? ☐Yes ☐No
6. Medications? ☐Yes ☐No Please list under medications

Gastrointestinal

1. Heartburn? ☐Yes ☐No
   If yes – how often a week? _____
2. Medications? ☐Yes ☐No Please list under medications
3. Do you get pain in your upper abdomen after eating or in the middle of the night other than heartburn? ☐Yes ☐No
4. Have you ever been told you have gallstones? ☐Yes ☐No
5. Have you ever been told you have a fatty liver? ☐Yes ☐No

Respiratory

1. Do you have asthma? ☐Yes ☐No
2. Do you have COPD/Emphysema?
   If yes – medications? ☐Yes ☐No Please list under medications
3. How far can you walk before you get short of breath? _____

Musculoskeletal

1. Do you have joint pain? ☐Yes ☐No
2. If yes – where? _____
3. Do you take medication for this? ☐Yes ☐No
   Please list under medications
4. Have you see an Orthopedic MD or this? ☐Yes ☐No
5. Have you had surgery for this? ☐Yes ☐No
   a. If yes – when and what? _____
6. Are you waiting for a joint replacement until you lose weight? ☐Yes ☐No

Any other medical history/conditions besides listed above?

_____

_____

_____

Medications (Including Vitamins): ☐ I currently do not take any medication

Medication	Dosage	Frequency	Comments

Please attach medication list if applicable

Thank you for taking the time to answer all the questions.

I certify that all the information that I provided on this questionnaire is true, accurate, and complete.