Harvard Vanguard Medical Associates
Atrius Health

Welcome to the weight management program at Kenmore. We are very excited to work with you to help you achieve your weight loss goal.

To help us to create a more individualized plan for you, please fill out this questionnaire prior to coming to your initial weight management appointment.

1. Please let us know your weight history:
   - Highest weight as an adult: _____ lbs.
   - Lowest weight that you can remember as an adult: _____ lbs. How long ago? _____
   - What do you think are some of the contributors for your weight gain in the past (i.e., stress, depression, illness, death or illness of a loved one, child birth, or gradual increase and I am uncertain what caused it)
     _____
     _____
     _____
   - Do you remember of any time in the past where you continued to eat even though you felt uncomfortable full? ___Yes ___No
   - Did you force yourself or felt that you had to vomit? ___Yes ___No
     (If yes, when was the last time that this happened?)
     _____
   - Goal weight in 6 months? _____ lbs.
     (Weight loss of 5-10% can cause significant improvements in your health.)
   - Ultimate goal weight? _____ lbs.
   - Family history of overweight or obesity (mother, father, siblings, aunts/uncles):
     _____-
     _____

2. Prior attempts at weight loss: successful or unsuccessful?
   - Diet and exercise:_____
   - Worked out with trainer:_____
   - Weight Watchers:_____
   - HMR: _____
   - Medications:_____
   - Any other weight loss program:_____

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3. Are you interested in taking medications to aid in weight loss? ___Yes ___No
4. How about bariatric surgery (weight loss surgery)? ___Yes ___No
5. Have you ever been evaluated for weight loss surgery? ___Yes ___No
   If yes, which program? _____
   Have you ever been declined? _____
6. Medical history:

   Any heart problems: (palpitations, chest pain, blockage of arteries in your heart, heart attack, problems with heart valve):

   _____
   _____

   Any psychiatric problems:
   - Elevated mood / or mania: _____
   - Bipolar disorder: _____
   - Depression (prior episodes or current): _____
   - Anxiety (prior episodes or current): _____

- Do you have any trouble falling asleep or staying asleep? _____
  - Even if you have 7-8 hours of sleep do you still feel tired in the next day?
  - Do you tend to fall asleep during the day (when working, watching TV)? _____
  - Do you snore? _____
  - Has anyone told you that you stop breathing while sleeping? _____
  - If you have Obstructive Sleep Apnea, do you use a CPAP machine? _____

- Have you have any of the following in the last few days or weeks, **please check all that apply**:
  - Feeling fatigued: ___ not at all ___ sometimes ___ often ___ all the time
  - Fever or chills
  - Any eye pain or vision problems, such as seeing double or having blurred vision
  - Chest pain or palpitations
  - Shortness of breath or difficulty breathing
  - Constipation, diarrhea, abdominal pain, heart burn (gastric reflux), changes in your bowel movements
  - Pain or burning with urination, frequent urination, or blood in the urine
  - Frequent headaches, any memory changes
  - Feeling depressed, having low energy, decrease interest in doing things that you usually enjoy, feeling blue or sad

Do you have any other medical problems or issues that are bothering you today?

_____
_____
_____

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DIET RECALL:

Please write what you had to eat in the last day or for the past few days (please give as much detail as possible):

What time do you wake up? _____

Breakfast: Time _____	Coffee: _____cream _____sugar _____ (how much) _____Splenda/Equal Cereal (what type and how much): Bread (how many slices and with anything on it): Anything else:
Snack: Time _____	
Lunch: Time _____	Be as descriptive as possible (if you are eating salad, soup or sandwiches, please describe each ingredient that you are using)
Snack: Time _____	
Dinner: Time _____	Be as descriptive as possible (if you are eating salad, soup or sandwiches, please describe each ingredient that you are using)
Dessert:	
After dinner snacks:	
Drinks:	Throughout the day (water, juice, soda, coffee, tea) and how much of each:

What type of physical activity do you do during the week?

I _____, _____ minutes per day, _____ times per week.

(*examples:* walk, go to the gym, take a Zumba class)