

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

(Preferred Name) _____ Current Age: _____ DOB: ____/____/____

Describe weight history:

0-12 years old Underweight Average Weight Overweight Very overweight or obese

13-18 years old Underweight Average Weight Overweight Very overweight or obese

19-35 years old Underweight Average Weight Overweight Very overweight or obese

35-50+ years old Underweight Average Weight Overweight Very overweight or obese

Highest (non-pregnant) weight: _____ lbs. When: _____ Weight at age 18: _____

If you had bariatric surgery, lowest weight achieved: _____ lbs. Lowest was after _____ months.

Current weight: _____ Current height: _____

Describe weight history. (Has gain been gradual or were there life events that affected weight, such as pregnancy, quitting smoking, emotional factors, personal issues, or job changes?)

Any current barriers to weight-loss? _____

What is your motivation for wanting to lose weight? _____

What are you hoping to get out of this program? _____

WEIGHT-LOSS ATTEMPTS

Previous weight-loss attempts (*Weight Watchers, Jenny Craig, Nutrisystem, Atkins, self-monitoring plan, work with dietitian, bariatric surgery, etc.*)

Name of attempt: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

Name of attempt: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

Weight-loss medications used (*Meridia, Orlistat, Qsymia, Belviq, Phentermine, HCG, Dexatrim, Metabolife*)

Name of medicine: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

Name of medicine: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

EATING HABITS

On a special diet currently (describe)? _____ Length of time: _____

 Diet restrictions, food allergies, chewing issues, dry mouth, dental problems? Yes No If yes, explain: _____

 Who does the grocery shopping: Self Other: _____

 Who does the meal preparation: Self Other: _____

 In last 12 months, did you worry about food running out before you got money to buy more? Yes No

 In last 12 months, did the food run out before you got money to buy more? Yes No

 On a limited food budget/rely on food stamps, food pantry for food? Yes No If yes, explain: _____

Mark if any of the following common issues often apply to you. Keep in mind that each person has different struggles.

 Irregular eating timing (variable eating times, lack of routine, skipping meals)
 Snacking between meals. If yes, explain: _____

 Majority of food is snacks rather than meals
 Eating quickly (less than 10 minutes)
 Portion sizes larger than needed
 Eating until uncomfortably full
Eating mindlessly (while doing something else, like watching TV, or in car). If yes, when? _____

Eating "out" (fast food, restaurant, carry-out, etc.) If yes, is it fast food, sit-down restaurant, take-out, cafeteria, or other: _____ Times per week: _____

 Emotional eating. If yes, how often, and triggers: _____

 Suspected addiction to any foods. If yes, explain: _____

 Hunger
 Have "problem" foods (that you crave or that trigger overeating like sweets or salty foods).

If yes, examples: _____

 Eat processed convenience foods (ex., ready-made, boxes meals). If yes, examples: _____

 Eating less than 5 servings total fruits and vegetables/day. Number fruit serving and examples: _____
 Number of vegetable servings and examples: _____

 Eating "sweets" (candy, cookies, etc.) Examples and frequency: _____

Poor support system (unsupportive friends/family) If yes, examples: _____

Often tempted to eat by foods seen or smelled, esp. at home or work. If yes, examples: _____

EATING HABITS - CONTINUED

Please indicate your servings of beverages in an average day:

Juice		<input type="checkbox"/> None	<input type="checkbox"/> less than 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6+
Soda	<input type="checkbox"/> Regular <input type="checkbox"/> Diet	<input type="checkbox"/> None	<input type="checkbox"/> less than 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6+
Tea	<input type="checkbox"/> Sweet <input type="checkbox"/> Un-sweet	<input type="checkbox"/> None	<input type="checkbox"/> less than 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6+
Coffee	<input type="checkbox"/> Cream <input type="checkbox"/> Sugar	<input type="checkbox"/> None	<input type="checkbox"/> less than 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6+
Water		<input type="checkbox"/> None	<input type="checkbox"/> less than 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6+

AUDIT C

In the past year:	0	1	2	3	4
How often did you have a drink containing alcohol?	Never	1 day per month or less	2-4 days per month	2-3 days per week	4+ days per week
On a typical day when drinking alcohol, how many drinks did you have?	1-2	3-4	5-6	7-9	10+
How often have you had 6+ drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Total Score: _____

Common alcoholic beverages consumed: _____

Describe food or beverage consumed in past 24 hours (include amount eaten and method of prep)	Time	Calories (if known)
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PHYSICAL ACTIVITY
Physical activity in a typical day NOT from formal exercise:
 Sedentary (sitting most of day) Active (standing most of day) Very active (walking most of day)

Physical activity from formal exercise:

Days/week exercise outside normal daily activity: _____ days (A)

Minutes each day exercise is performed: _____ minutes (B)

Days (A) x minutes (B) = _____ minutes per week (Physical Activity Vital Sign)

Describe: _____

How many days per week muscle strengthening exercises? _____ days

Describe: _____

Describe any activity limitations: _____

 Able to stand or walk by one's self for greater than 15 minutes without pain/need to sit? **Yes** **No**

Time spent on TV in a day (hours): _____ Time spent on computer/phone in a day (hours): _____

SLEEP EVALUATION

Average hours of sleep per night: _____

 Do you often have insomnia? Yes No

 Do you wake up tired after a night's sleep (non-restorative sleep)? Yes No

PROMIS Sleep: Circle the appropriate choice that describes your sleep in the past 7 days

In the past 7 days	1	2	3	4	5
My sleep was restless	Not at all	A little bit	Somewhat	Quite a bit	Very much
I was satisfied with my sleep	Very much	Quite a bit	Somewhat	A little bit	Not at all
My sleep was refreshing	Very much	Quite a bit	Somewhat	A little bit	Not at all
I had difficulty falling asleep	Not at all	A little bit	Somewhat	Quite a bit	Very much
I had trouble staying asleep	Never	Rarely	Sometimes	Often	Always
I had trouble sleeping	Never	Rarely	Sometimes	Often	Always
I got enough sleep	Always	Often	Sometimes	Rarely	Never
My sleep quality was	Very good	Good	Fair	Poor	Very Poor

Total Score: _____

 Do you have Sleep Apnea? Yes No

 If yes, do you wear a CPAP or Bipap machine at night? Yes No

Epworth

If you are NOT currently being treated for sleep apnea, please answer the questions below.

- Do you snore? Yes No
- Has anyone ever told you that you stopped breathing at night? Yes No
- Do you wake up at night gasping for breath or wake up feeling as if you are smothering? Yes No

If you are NOT currently being treated for sleep apnea, use the scale below to choose the best number to rate each situation and your chance of dozing off during these situations.

Scale: 0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon, when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total: _____

SOCIAL HISTORYRelationship status: **Single** **Married** **Divorced** **Separated** **Widow** **Life Partner**

Who lives in the home with you? _____

Do you have children? **Yes** **No** If yes, how many? _____Do you currently use tobacco products? **Yes** **No** If yes, how much and what type: _____Do you currently use Marijuana products? **Yes** **No**

Highest level of education: _____

What is your occupation? _____ Do you work night shifts? **Yes** **No****FAMILY HISTORY**

Please indicate if there is a family history of:

Overweight/Obesity **Child** **Mother** **Father** **Sister** **Brother** **Other:** _____Diabetes (Type II) **Child** **Mother** **Father** **Sister** **Brother** **Other:** _____Thyroid Cancer **Child** **Mother** **Father** **Sister** **Brother** **Other:** _____Stroke **Child** **Mother** **Father** **Sister** **Brother** **Other:** _____Heart Disease **Child** **Mother** **Father** **Sister** **Brother** **Other:** _____

Other notable family history, such as cancer: _____

PAST MEDICAL HISTORYAre you a WVU Medicine patient? **Yes** **No**

If yes, go to the next page if you prefer we obtain the information below from reviewing your electronic health record with you.

Please list chronic medical conditions: (diabetes mellitus, high blood pressure, cancer, heart or lung disease)

Please list any previous surgeries (include any biopsy or cosmetic surgery)

Please list any prescription medications that you are currently taking: (including over the counter supplies, supplements, vitamins, or herbals)

Name	Dosage instruction	Name	Dosage instruction
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS

- Do you have a history of glaucoma? Yes No If yes, detail _____
- Do you have any other serious eye disorders? Yes No If yes, detail _____
- Have you ever had diabetes (even if remission)? Yes No If yes, detail _____
- Do you feel thirsty frequently or urinate often? Yes No If yes, detail _____
- Do you have a history of thyroid disease? Yes No If yes, detail _____
- Do you get chest pain? Yes No If yes, detail _____
- Do you have a history of heart valve problems? Yes No If yes, detail _____
- Do you have a history of heart disease, coronary artery disease, heart attack, coronary artery bypass, angioplasty, heart stent, arrhythmia? Yes No If yes, detail _____
- Do you have congestive heart failure? Yes No If yes, detail _____
- Have you had any testing done on your heart? Yes No If yes, detail _____
- Do you have asthma, shortness of breath, or wheezing? Yes No If yes, detail _____
- Do you have a history of sleep apnea? Yes No If yes, detail _____
- Do you have a history of GERD (acid reflux)? Yes No If yes, detail _____
- Do you frequently get abdominal pain? Yes No If yes, detail _____
- Do you get nausea, vomiting, constipation, diarrhea? Yes No If yes, detail _____
- Do you have a history of pancreatitis? Yes No If yes, detail _____
- Do you have a history of liver problems or high liver enzymes? Yes No If yes, detail _____
- Do you have a history of bladder leakage? Yes No If yes, detail _____
- Do you have a history of kidney stones? Yes No If yes, detail _____
- Do you have problems with sexuality, such as loss of desire or erectile dysfunction? Yes No If yes, detail _____
- Do you get headaches or ever had migraines? Yes No If yes, detail _____
- Do you have a history of a stroke or mini-stroke? Yes No If yes, detail _____
- Do you have a history of seizures? Yes No If yes, detail _____
- Do you have a history of joint pain? Yes No If yes, detail _____
- Do you have a history of gout? Yes No If yes, detail _____
- Were you born by C-section? Yes No If yes, detail _____
- Were you solely bottlefed formula as a baby? Yes No If yes, detail _____
- Do you have a history of depression? Yes No If yes, detail _____
- Do you have a history of anxiety? Yes No If yes, detail _____
- Do you have a history of Post Traumatic Stress Disorder (PTSD)? Yes No If yes, detail _____
- Do you have any other mental health condition? Yes No If yes, detail _____
- Do you have a history of substance abuse or addiction? Yes No If yes, detail _____
- Do you have a history of anorexia or bulimia? Yes No If yes, detail _____
- Would you rate your stress level as high? Yes No If yes, detail _____
- Women only: Do you have irregular periods or PCOS? Yes No If yes, detail _____
- Women only: Do you have a history of infertility? Yes No If yes, detail _____
- Women only: Are you planning pregnancy in next year or at risk for it and not using birth control? Yes No If yes, detail _____
- Women only: Did you have pregnancy complications? Yes No If yes, detail _____

BEHAVIORAL HEALTH

- 1. Do you ever make yourself sick because you feel uncomfortably full? Yes No
- 2. Do you worry you have lost control over how much you eat? Yes No
- 3. Have you recently lost more than one pound in a three month period? Yes No
- 4. Do you believe yourself to be fat when others say you are too thin? Yes No
- 5. Would you say that food dominates your life? Yes No

Total of yes answers: _____

Using the scale below, choose the best number to best describe how often you have been bothered in the **last two weeks**.

Scale: 0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day

Situation

Scale

Feeling nervous, anxious, or on edge

Not being able to stop or control worrying

Worrying too much about different things

Trouble relaxing

Being so restless that it's hard to sit still

Becoming easily annoyed or irritable

Feeling afraid, as if something awful might happen

Total:

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Trouble falling or staying asleep, or sleeping too much

Feeling tired or having little energy

Poor appetite or overeating

Feeling bad about yourself, that you are a failure, or have let yourself or your family down

Trouble concentrating, like when reading the paper or watching TV

Moving or speaking so slowly that others could have noticed. Or so fidgety/ restless that you've been moving more than usual

Thoughts that you would be better off dead or of hurting yourself

Total:

BEHAVIORAL HEALTH - CONTINUED**During the last three months:**

A. Did you have any episodes of excessive overeating (eating significantly more than what most people would eat in a similar time)? **Yes** **No** If “no” you do not need to fill out the rest of this page. **If “yes,” continue to B.**

B. Do you feel distressed about your episodes of excessive overeating? **Yes** **No**

If “no,” you do not need to fill out the bottom portion of this page. **If “yes,” see below.**

Statement about feelings during episodes (only do if you answered yes to B above.)

How often did you feel you had no control (not able to stop, compelled to eat, go back and forth for more food)?

Never or rarely **Sometimes** **Often** **Always**

How often did you continue eating even though not hungry?

Never or rarely **Sometimes** **Often** **Always**

How often were you embarrassed by how much you ate?

Never or rarely **Sometimes** **Often** **Always**

How often did you feel disgusted with self or guilty after?

Never or rarely **Sometimes** **Often** **Always**

During last 3 months, how often did you make yourself vomit to try to control your weight or shape?

Never or rarely **Sometimes** **Often** **Always**

CHOICES AND GOALS

Please indicate choices, if known. May discuss first at appointment.

Food: The program includes several eating pattern options (indicate 1st and 2nd choices.)

- | | |
|--|---|
| <input type="checkbox"/> Flexible healthy eating pattern | <input type="checkbox"/> Meal replacements (Fresh Steps; separate track with additional cost) |
| <input type="checkbox"/> Mediterranean or similar eating pattern | <input type="checkbox"/> Other (name) _____ |
| <input type="checkbox"/> Plant-based or vegetarian—describe: _____ | |

Movement: The program includes physical activity. Please indicate your choice(s):

- | | |
|--|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Physical Therapy (currently in or need) |
| <input type="checkbox"/> Human Performance Lab (additional fee; recommend initial and periodic evaluations at minimum) | <input type="checkbox"/> Gym (name) _____ |
| | <input type="checkbox"/> Other (name) _____ |

Are there any other types of physical activity you would enjoy and may consider adding? _____

Behavior: The program includes self-monitoring. How would you like to log your food and behaviors?:

Paper **App** If app, please name: _____

The program includes goal-setting. What lifestyle change goals would you like to make or maintain?

Your personal goal weight: _____ lbs.

Optional supplemental programs can provide support. Please indicate your interest in these programs below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Finding Wellness | <input type="checkbox"/> Diabetes Prevention Program | <input type="checkbox"/> Commercial program; please name: _____ |
| <input type="checkbox"/> Referral to psychologist | <input type="checkbox"/> Community program; please name: _____ | |

Shared Medical Appointments (SMAs). SMAs include an educational discussion and a medical visit in a group setting. They are highly recommended as the support has been shown to help with weight loss. Participating in SMAs may enable you to be seen more often.

Medical: The program may include prescription weight-loss medications or bariatric surgery if you are a candidate (will be decided by the medical physician and/or bariatric surgeon).

Please indicate if you would consider these options:

Medications: **Yes** **No** **Maybe if needed later** Comments: _____

Bariatric surgery: **Yes** **No** **Maybe if needed later** Comments: _____

TRACKS

Please indicate a preferred track, if known. May discuss first at appointment.

____ 1. **Weight-loss and Wellness track:** Food-based track. These monthly visits can be either individual visits or Shared Medical Appointments (SMAs), as detailed above. Some patients like to alternate between an individual visit and an SMA, and the exact schedule of appointments is individualized to each patient's needs.

____ 2. **Fresh Steps Meal System track:** Involves purchasing a separate meal system. This track may be a good option for those needing to lose weight quickly, such as before surgery.