INITIAL Obesity Medicine ADULT Patient Intake Form Date: __/__/__

Patient Name: (First)_____ (Last_____
Date of Birth: _____/_____/_____ Gender: M / F AGE:
Best Contact Phone: _____ 2nd contact phone:
Email: _____ Email may be used for communication? Yes/No
Primary Care Provider: _____.

Are there any specific QUESTIONS or EXPECTATIONS for today's visit?

Please explain WHY you would like to lose weight or get healthier

Around what age did your weight become a concern?

What has been your highest weight, and at what weight did that occur?

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Have you ever tried to lose weight before? □ YES □ NO
If YES, what have you tried? (diet/nutrition, exercise/physical activity programs, apps, websites, etc)

_____

Were you successful? □ YES □ NO
What do you think has contributed the most to your weight gain?

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Past Medical History (check all that apply): □ NONE

□ Heart problem □ Gallbladder stones □ Sleep apnea □ Pre-Diabetes
□ Indigestion/reflux □ Thyroid problem □High Blood Pressure □ Diabetes
□ Kidney Problems □ High cholesterol □ Depression/Anxiety □ Polycystic Ovarian Syndrome □ Asthma □ Constipation □ Prematurity
□ Low or high birth weight
□ Developmental Delay □ Bone/Joint problems □ ADHD □ Behavior or learning problem
□ Early puberty (female< 8 yrs, boys<9 yrs): Age of 1st menstrual cycle:
□ OTHER:

Past Hospitalizations: □ None

□ _____

Past Surgeries: □ None

□_____

Past/Current Specialists: □ None

□ _____

Medications (list any current medications & dose, including over-the-counter medications, supplements, and herbs):

□ None □_____ □_____ □ .

Allergies: □ None □ To

Medications:_____

□ To Food/Other:_____

Family History (check all that apply):

Obesity or Overweight:	□ Mother	□ Father	□ Sibling	□ Grandparent –
High Cholesterol:	□ Mother	□ Father	□ Sibling	□ Grandparent –
High Blood pressure:	□ Mother	□ Father	□ Sibling	□ Grandparent –
Heart Disease (M<55,F<65):	□ Mother	□ Father	□ Sibling	□ Grandparent –
Thyroid Disease:	□ Mother	□ Father	□ Sibling	□ Grandparent –
Diabetes:	□ Mother	□ Father	□ Sibling	□ Grandparent –

Did your mother have diabetes during pregnancy? □Yes □No

Other family medical problems (please explain):

_____

Social History:

Please list all people who live in your home:

Relationship to you? (ex: mother/father/child)	Any Weight concerns? (Y/N)	Age	Employment/ Education

Who does the grocery shopping for the house? _____.

Who does the cooking in the home? _____.

What type of physical activities do you like to do? _____.

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Number of hours of sleep you get per night? **Typical bedtime/wake up time:**	**9+**	**8**	**7**	**≤6**
Number of hours of screen time on weekdays? **Number of hours of screen time on weekend?**	**>3 hrs** **> 3 hrs**	**2-3 hrs** **2-3 hrs**	**1-2 hrs** **1-2 hrs**	**<1 hr** **<1 hr**

What does a typical day of eating look like for you?
Breakfast:
Lunch:
Dinner:
Snacks per day: **What types of snacks?** **Time of day you snack?**
Typical Drinks (milk, water, soda, Gatorade, tea, etc?)

Symptom Review (Check any symptoms that child has had **in the past 2 weeks:**)

□ Shortness of breath
□ Chest pain or heart racing
□ Passing Out or Dizzy
□ Cough
□ Stress from Being Bullied
□ Trouble Sleeping
□ Sleeping too much
□ High Stress
□ Feeling depressed or anxious
□ Poor self-esteem
□ Extremely Thirsty
□ Extremely Hungry
□ Frequent urination
□ Heartburn or reflux
□ Gas or bloating
□ Diarrhea
□ Constipation
□ Nausea or Vomiting
□ Abdominal Pain
□ Irregular or heavy periods
□ Skin rash
□ Acne or Facial Hair
□ Dry skin/hair
□ Joint pain (hips, knees, feet, etc)
□ Muscle aches/pain
□ Lack of energy, tired, fatigued
□ Often Feels Cold
□ Blurry, Double vision
□ Frequent Headaches
□ Bedwetting
□ Poor satiety: Not satisfied after eating, frequently hungry again
□ Frequent Cravings (Example: for sweets)
□ Low appetite and limited calories yet still gaining weight
□ Emotional eater (Eating often due to stress, emotions)
□ Hunger above average
□ Binging/Uncontrollable eating
□ Wakes up to eat at night
□ Sneaks/hides food
□ Skips Meals

On a scale of 1-10, with 1 being NOT ready to change at all and 10 being extremely READY to change:

How **ready** are you to make changes?	**(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**

On a scale of 1-10, with 1 being NOT at all confident and 10 is VERY confident:

How **confident** are you in your ability to change?	**(CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10**

Please list any BARRIERS that may prevent you from making lifestyle changes:

Please list any STRENGTHS that you have that will help you to make healthier choices?

How will you CELEBRATE success?

By signing below I acknowledge that I am ready and willing to make healthy lifestyle changes. I understand the 4 pillars of obesity medicine are nutrition, physical activity, behavioral modification and medical intervention.

_____ _____

Patient Name Date

_____

Patient Signature

By signing below, I agree that obesity medicine visits are purely related to obesity management. I agree that if other concerns arise during the obesity medicine visit, I will need to follow up with my primary care provider. By signing below I also agree to medical consent for treatment and all associated consent documents in the initial intake form (Your Health Information Privacy Practices, Written Acknowledgement of Receipt of NW Cypress Pediatrics and Family Medicine, PLLC Consent and Notice of Privacy Practices, General Consent to treat, Electronic Medical Records and Electronic Prescriptions, Office Policy, and Payment Policy).

_____ _____

Patient Name Date

_____

Patient Signature