Name: ___________________________________ **Date:** _________________________

Revised 6-24-13

Oregon Medical Weight Loss

Patient Intake Information

Best # to reach you ________________________ May we leave a message here, for you? (Y/N)
Alternate Phone: _________________________ May we leave a message here, for you? (Y/N)
Address:________________________________ Email address _______________________________________
City________________State_____Zip_______ May we send you email information about weight loss? (Y / N)
Age ________________D.O.B.____________ Primary Care Provider________________________________
Occupation_____________________________ What is your Preliminary Goal Weight?_________________

How did you hear about us? □ I'm a current patient □ A friend □ Referred by _________________________
On line via: □ Oregon Medical Weight Loss □ SW Family Physicians □ Other________________________

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form in its entirety.

Current Marital Status (circle one): Single Engaged Married Separated Divorced Widowed Domestic Partner
Are you content with your current status? (Y/N) _____ If no, please explain: ____________________________
____
What is your main reason for deciding to lose weight now? ____
List activities you are **not** doing now, but would **like** to do in the future: ________________________________
When did you begin gaining excess weight? (Give reasons if known): ______________________________
____
What has been your maximum lifetime weight (non-pregnant) and when? ______________________________
Has your weight changed in the last 2-3 months? ____
Any history of eating disorders, now or in the past? Please explain ________________________________
____
What are your expectations of us (your medical team)? Be specific: ________________________________
____

Previous diets you have followed:	Dates	Results of your weight loss:	Any weight regained?:

Which was you best "diet success" and why did it work well for you. ____
____

How often do you eat out? ______________________ How often do you eat "fast foods"? ___________________________
In your household, who plans meals? ________________ Cooks? ________________ Shops? ______________________
Is your spouse or partner overweight? NO YES If so, approximately how much?_________________________________
Foods you crave? ____
What are your worst food habits? ____
Please describe your snack habits: ____
Do you awaken hungry or eat during the night? YES NO
Do you feel you are an emotional eater? YES NO Please list circumstances that trigger this emotional eating behavior.
____
Have you used appetite suppressants in the past? YES NO If so, which ones? __________________________
What were the results? ____
If your favorite food is in the refrigerator, do you find it hard to sleep well? YES NO

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Typical Breakfast	**Typical Lunch**	**Typical Dinner**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Please list any conditions, illnesses, or treatments that might be relevant to your visit today: ________________

____

____

Do you feel you are you in good health at the present time? YES NO If not, why?

Are you under any other doctor's care at the present time? If yes, Who? (and for what)____________________

____

Do you drink sodas? YES NO How much daily? ____________________ Do you use a sugar substitute? YES NO

Do you drink alcohol? YES NO How much daily/weekly? ____

Do you drink coffee or tea? YES NO How much daily? ____

Smoking Habits:

___ I have never smoked cigarettes, cigars, or a pipe.

___ I quit smoking _____ years ago and have not smoked since.

___ I quit smoking at least one year ago and now smoke cigars or a pipe w/out inhaling smoke.

___ I smoke approx _____cigarettes per day (_____ pack/s)

Any Medication Allergies? **Food Allergies?**

Please list all prescription medications you are taking at the present time:

Drug: **Dosage:** **Taken for what reason?**

Any over-the-counter medications, vitamins, herbs, supplements or natural remedies?

Serious Injuries/ Surgeries (please list all)____________________ Date____________________

Behavioral Health

When you are in a stressful situation that is work or family related, do you tend to eat more? Explain_________

____

____

Are you currently undergoing any stress or emotional upset? Explain: ________________________________

____

Are you currently experiencing any suicidal thoughts? ____

Have you seen a mental health provider for services? Please explain:____________________________________

Have you ever been hospitalized for psychiatric, drug, or alcohol addiction? ___________________________

Date:______________ Hospital:______________________ Diagnosis: __________________________

Name: ___________________________________ **Date:** _________________________

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OB/Gynecologic History: (Women only)

Number of Pregnancies: ____________ Vaginal Delivery or C-Section: ________________________________

Babies over 9 lbs? YES/NO If yes what were their weights? _______________________

Menstrual Onset: _______ yrs old Duration: _______ days Last menstrual period: _________

Do you have pain associated with menstrual cycle? YES/NO Are menses heavy? ___________

Are you on Birth Control? YES/NO If yes, please list: ________________________________

On Hormone Replacement Therapy? YES/NO If yes, please list: ________________________________

When was your last Physical/ PAP? ____

Check ALL the weight related Risks or Diagnoses that you may have:

- ❑ Abdominal Pains
- ❑ Abnormal EKG
- ❑ Abnormal Weight Gain
- ❑ Anemia
- ❑ Anorexia Nervosa (now or in the past)
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Breast Cancer
- ❑ Binge Eating patterns/disorder
- ❑ Bulimia/Purging (exercise, laxatives, vomiting, diuretics)
- ❑ Constipation
- ❑ Cushing's Syndrome
- ❑ Decreased Libido
- ❑ Depression/dysthymia
- ❑ Diarrhea
- ❑ Diabetes or
  - ❑ Pre-diabetes
- ❑ Dizziness
- ❑ Eating in the middle of the night
- ❑ Elevated Liver Enzymes
- ❑ Fatigue ❑ Excessive Daytime Fatigue
- ❑ Fibromyalgia
- ❑ Frequent Headaches
- ❑ GERD
- ❑ Heartburn
- ❑ Gestational Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hip Pain
- ❑ High Blood Pressure
- ❑ "Pre-Hypertension"
- ❑ High Cholesterol
- ❑ Triglycerides
- ❑ Insomnia
- ❑ Irritable Bowel
- ❑ Knee Pain
- ❑ Low Back Pain
- ❑ Low Blood Sugars
- ❑ Low Testosterone
- ❑ Menopause
- ❑ Migraines
- ❑ Muscle Spasm
- ❑ Nausea
- ❑ Vomiting
- ❑ Osteoporosis
- ❑ Panic Attacks
- ❑ Painful, heavy, or irregular menses
- ❑ Plantar Fasciitis
- ❑ Polycystic Ovarian Syndrome
- ❑ Psoriasis
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Swelling feet or ankles
- ❑ Thyroid Disorder: ❑ High ❑ Low
- ❑ Ulcer
- ❑ Urinary Stress Incontinence
- ❑ Vitamin D Deficiency

Family History:

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative had any of the following:

Glaucoma:	YES	NO	Who: ______________________________
Asthma:	YES	NO	Who: ______________________________
Epilepsy:	YES	NO	Who: ______________________________
High Blood Pressure:	YES	NO	Who: ______________________________
Kidney Disease:	YES	NO	Who: ______________________________

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Diabetes:	YES	NO	Who: ____
Psychiatric Disorder:	YES	NO	Who: ____
Heart Attack:	YES	NO	Who: ____
Heart Disease:	YES	NO	Who: ____
Stroke:	YES	NO	Who: ____
Overweight/Obesity	YES	NO	Who: ____

Activity Level (answer only one):

___ Inactive/ Sedentary- includes only the light physical activity associated with typical day-to-day life

___ Moderate Activity- includes physical activity equivalent to walking about 1.5 to 3 miles per day at 3 to 4 miles per hour (in addition to the light physical activity associated with typical day-to-day life)

___ Active- includes physical activity equivalent to walking more than 3 miles per day at 3 to 4 miles per hour, (in addition to the light physical activity associated with typical day-to-day life)

Please check all that apply to you currently

- ☐ Stress
- ☐ Unhappiness
- ☐ Inferiority feelings
- ☐ Fears
- ☐ Depression
- ☐ Anger
- ☐ Racing thoughts
- ☐ Friends
- ☐ Impulsive behavior
- ☐ Ambition
- ☐ Finances
- ☐ Panic
- ☐ Apathy
- ☐ Hopelessness
- ☐ Alcohol use
- ☐ Temper
- ☐ Physical abuse
- ☐ Problems concentrating
- ☐ Loss of control
- ☐ Sexual problems
- ☐ Death
- ☐ Pregnancy
- ☐ Making decisions
- ☐ Parenting
- ☐ Unwanted thoughts
- ☐ Abortion
- ☐ Shyness
- ☐ Communication
- ☐ Sexual abuse
- ☐ Bad dreams
- ☐ Marriage
- ☐ Trauma/disaster
- ☐ Trouble with job
- ☐ Children
- ☐ Nervousness
- ☐ Emotional abuse
- ☐ Anxiety
- ☐ Guilt
- ☐ Grief
- ☐ Loneliness
- ☐ Memory loss
- ☐ Compulsivity
- ☐ Legal matters

Please indicate your level of **motivation to lose weight** on the scale below:

____

0	**5**	**10**
Unmotivated	**Neutral/Unsure**	**Very Motivated**

Do you have any interest in getting more information about how the other specialties in our clinic may enhance or assist you in your weight loss? (Please circle all that apply):

Nutritional Counseling - Acupuncture - Medi-Spa - Physical Therapy - Massage Therapy - Mental Health/ Counseling - Personal Training

Signature:____