

GENERAL INFORMATION AND MEDICAL HISTORY

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Driver's License# _____ Date of Birth _____

Referred by _____

Email Address _____ Occupation _____

MEDICATIONS

List medications you are presently taking (over-the-counter and prescription drugs), including dose and frequency. _____

MEDICAL HISTORY

Place an "X" next to any of the following conditions that you have now or have ever had:

- | | | |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood Clotting Problem |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Constipation | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Swelling of ankles/feet | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pain/swelling in joints |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Stomach/duodenal ulcer | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Circulation deficiency | <input type="checkbox"/> Liver disease (hepatitis) | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies (Drug) |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Psychiatric illness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> High cholesterol level | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Alcoholism/substance abuse | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other |

Explain other _____

Are you currently being treated for a condition not listed? If yes, please specify:

SURGICAL HISTORY

List all operations and dates:

Year	Operation
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please include if there is a history of diabetes, high blood pressure, cancer, or coronary heart disease among relatives in your family.

Relative	Age	Use this column if living	Use this column if deceased	Age
		State of Health	Cause of Death	
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Comments	_____			

GYN HISTORY

Women only...

Age at onset of menstrual cycle _____ Date of last period _____

Are your periods regular? _____ Date of last pregnancy _____

Are you taking birth control pills? _____ Hormone replacement therapy? _____

Fluid retention _____ Slight _____ Moderate _____ Severe _____

If you are not menstruating, give age of menopause_____

If you are presently experiencing menopause, are you having any symptoms?

_____ No _____ Yes

Signature: _____

(Patient)

Signature: _____

(Physician)

NUTRITION HISTORY

Do you frequently skip meals? _____ Yes _____ No

If yes, which ones? _____ Breakfast _____ Lunch _____ Dinner

Who plans meals? _____ Cooks? _____ Food Shops? _____

How many times per week do you eat in a restaurant? _____ 0-2 _____ 3-5 _____ 6 or more

How many times per week do you eat fast foods? _____ 0-2 _____ 3-5 _____ 6 or more

How often are the following meals eaten out? _____ Breakfast _____ Lunch _____ Dinner

How often do you snack between meals? _____

Do you drink alcohol? _____ Yes _____ No If yes, what type? _____

Weekly intake of alcohol _____ Do you smoke? _____ Yes _____ No

Do you drink coffee/tea/soda? _____ Yes _____ No If yes, how many cups daily? _____

What are the foods you crave the most? _____

What are your worst food habits? _____

Please list any food allergies or food dislikes:

Food Allergies

Food Dislikes

Please list any vitamin, mineral, nutritional supplements, herbs or “natural remedies” you are presently taking:

Are you following any special diet? _____ If yes, please specify: _____

EXERCISE HISTORY

In general, how many times per week do you exercise? _____ None _____ 1-2 _____ 3 or more

List the type (including duration) of activities you most often do for exercise:

Type	Duration
_____	_____
_____	_____
_____	_____

EMOTIONAL/BEHAVIORAL ISSUES

Are your physical activities restricted for any medical reasons? _____

Is exercising consistently a struggle for you? _____

If yes, list reasons: _____

Have you ever diagnosed with an eating disorder? _____ If yes, when? _____

Where? _____ Treatment _____

Do you frequently eat when you are not physically hungry? _____

What feelings or situations trigger you to eat even though you are not hungry?

_____ Anger _____ Celebrations _____ Loneliness

_____ Anxiety/nervousness _____ Depression _____ Stress

_____ Boredom _____ Family gatherings _____ Social situations

Do you struggle with binge eating? _____ Frequently _____ Occasionally _____ Rarely

Do you give too much time and thought to food? _____ Yes _____ No

Is your weight affecting the way you live your life? _____ Yes _____ No

Do you have feelings of guilt and remorse after overeating? _____ Yes _____ No

Are there any personal problems/situations you have experienced or anticipate experiencing (i.e. relationships, job changes) that may affect your weight loss efforts?

_____ Yes _____ No If yes, explain _____

Have you ever been treated for a psychiatric diagnosis? _____ Yes _____ No

If yes, what was the diagnosis? _____

What was the treatment? _____

Were you overweight as a child? _____ Yes _____ No As a teenager? _____ Yes _____ No

What was your lowest adult weight? _____ lbs. at age _____.

When did you begin gaining excess weight (give reasons, if known)?

Are any of the following family members overweight?

_____ Spouse _____ Mother _____ Father _____ Brother _____ Sister

What is your goal weight (i.e. realistic, healthy weight)? _____

Which of the following weight loss programs have you tried?

_____ Diet Center _____ Weight Watchers _____ Nutri-System

_____ Jenny Craig _____ Own Program _____ Other

_____ R.D. Counseling _____ Liquid Diet

_____ Overeaters Anonymous _____ Physician Program

How many times have you lost and regained weight? _____ 0-1 _____ 2-4 _____ 5-10 _____ Other

If you have lost and regained weight, what are the main reasons you regained weight?

How motivated are you to lose weight?

_____ Extremely _____ Moderately _____ Somewhat _____ A little

How committed are you to making lifestyle changes?

_____ Extremely _____ Moderately _____ Somewhat _____ A little

List the foods your typical meals and/or snacks would consist of (including serving size):

Breakfast

Lunch

Dinner

Signed: _____ Date: _____

Patient

Signed: _____ Date: _____

Parent/Guardian if patient is a minor (under 18)

CONSENT FOR RELEASE
OF MEDICAL RECORDS

I hereby give my consent to allow my medical records (i.e. x-rays, lab reports, progress notes, etc.) to be copied, received and added to my medical record upon request of the physicians at The Weigh Station.

I hereby give my consent for the physicians at The Weigh Station to discuss my medical history and my weight loss progress and weight loss program with consulting physicians and/or my primary care physician.

Date: _____

Signature: _____

Patient

Signature: _____

Parent/Guardian (if patient is a minor under 18)

THE WEIGH STATION

Informed Consent

I, _____, have been informed of the possible side effects of using anorectic medications and of rapid weight loss. These side effects include, but are not limited to, the possibility of cardiovascular effects, depression, increased blood pressure, nervousness, dry mouth, trouble sleeping, diarrhea, drowsiness, or sedation, or impaired concentration, and the risk of gall bladder disease with rapid weight loss. I understand that a serious, but rare disease of pulmonary hypertension has been associated with the use of medications used for weight control and that the risk is estimated to be approximately 18 to 42 cases per million people (about 1 in 20,000) who take the medications, according to the International Primary Hypertension Study. I am not pregnant, and I understand that the use of these medications are contraindicated during pregnancy or breast feeding. I also understand that if I am planning elective surgery under general anesthesia I am advised to discontinue the medications two weeks before the surgical procedure. I understand that complications with anorectic medications may continue to be found as their use increases in the general population. Nevertheless, after being fully informed of the nature, risk, possible alternative methods of treatment, and possible complications involved in the treatment of obesity by prescribed medications, including those used for conditions outside their PDR labeling, I hereby consent and authorize such treatment and prescription by The Weigh Station physician.

It has been explained to me that the medications, while decreasing appetite and increasing metabolism, work best with regular physical activity and moderate eating patterns. I also understand that in accordance with the American Society of Bariatric Physician's guidelines and the Virginia Board of Medicine regulations a weight loss of at least a pound per week is necessary to continue medications past twelve weeks. I also understand that about 10% of patients may be minimally responsive to medications. It has been explained to me that obesity is a chronic disease and may require therapy over the long term. Also, I have been told that weight loss may slow or plateau periodically before I reach my goal size or weight and that doses may be adjusted or other medications substituted. I understand maintenance policy has been explained to me. In accordance with Virginia law, the Weigh Station staff, employees or consulting physicians make no implied or stated otherwise guarantees of any programs or therapies. I also understand that I may be dismissed/discharged from The Weigh Station, Inc. by its physicians or staff at will. I also understand that the use of tobacco products and alcohol is contraindicated with all of the programs available at The Weigh Station.

Signed: _____

Parent: _____ (If patient is a minor -12 to 18)

Date: _____

Witness: _____

