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**Currently Considering Weight Loss Procedure:**

* Laparoscopic Gastric Bypass
* Lap Band
* Laparoscopic Sleeve Gastrectomy
* Laparoscopic Duodenal Switch
* Revision Surgery
* Novant Health Bariatric **Weight Loss** Management (non-surgical)

**GOALS:**

What are the top 3 reasons why you currently want to get to a healthier weight?

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT HISTORY:**Present Weight \_\_\_\_\_  
Highest Weight \_\_\_\_\_  
Weight one year ago \_\_\_\_\_  
Lowest adult weight \_\_\_\_\_ How old were you at that time? \_\_\_\_\_  
What is your “Dream Weight”? \_\_\_\_\_  
What weight would you be reasonably satisfied with? \_\_\_

\_\_

**Weight History (cont.)**

What is the most weight you have lost at once? \_\_\_\_\_\_\_\_\_\_   
How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle or add all weight loss programs you have done in the past 10 years:**

|  |  |  |  |
| --- | --- | --- | --- |
| Worked with Dietician | Low Fat Diet | Low Calorie Diet | Slim Fast |
| Nutrisystem | Jenny Craig | Weight Watchers | Atkins |
| 21-Day Fix | Physician Supervised Diet Plan | MediFast Weight Loss Center | Liquid diet (such as OptiFast shakes) |
| Overeaters Anonymous | Phentermine | Metabolife | SouthBeach |
| OTHER: |  |  |  |

**EXERCISE HISTORY:**   
Please circle number of days per week you currently exercise? 0 1 2 3 4 5 6 7  
What types of exercise do you *currently* do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
How many minutes do you exercise at a time? under 10 20-30 30-40 40-50 50-60 or more

What types of exercise have you done in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which types of exercise do you enjoy/used to enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
What limits your activity now? (for example, joint pain or back pain, chest pain or shortness of breath,   
problems with vision, other problems) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you use any of the following (check any that apply) cane walker wheelchair other  
Have you ever been told by a healthcare profession that you CANNOT exercise? Yes / No.   
If yes, please provide name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Difficult areas in exercise**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle the type of exercise you are currently doing or have done in the past**

|  |  |  |
| --- | --- | --- |
| Exercise Equipment | Treadmill | Weights |
| YMCA | Curves | Other Gyms |
| Walking | Running | Cross Fit |
| Other: |  |  |

**CURRENT EATING HABITS:**   
Number of regular meals per day: \_\_\_\_\_\_\_\_\_

Number of snacking episodes per day: \_\_\_\_\_\_\_\_\_  
- Typical breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Typical lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Typical dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Typical snack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who else lives in your home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Who cooks/prepares meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who shops for groceries? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you tend to eat more when under stress? \_\_\_\_\_\_\_\_\_

Do you tend to eat when bored? \_\_\_\_\_\_\_\_\_  
Do you ever eat until you are so full that you feel uncomfortable? \_\_\_\_\_   
If yes, how often? (few times a year/ few times a month/ few times a week/ almost daily)

Any feelings of guilt associated with eating? \_\_\_\_\_\_\_\_\_  
Any history of an eating disorder (such as anorexia, bulimia, binge eating disorder)? \_\_\_\_\_\_\_

Do you feel a loss of control with eating? \_\_\_\_\_\_\_\_\_

How often to you eat fried foods? \_\_\_\_\_\_

How many times do you eat fast food per week: \_\_\_\_\_\_  
Which fast food restaurants do you typically go to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Which foods and drinks do you get there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times do you go to sit-down restaurants per week: \_\_\_\_\_\_  
Which foods and drinks do you get there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_\_ Number of drinks per week \_\_\_\_\_\_ Types of alcohol drinks \_\_\_\_

Do you drink sodas \_\_\_\_\_\_ Number of drinks per week \_\_\_\_\_\_

Do you drink sweet tea \_\_\_\_\_\_ Number of drinks per week \_\_\_\_\_\_  
Do you drink juice? \_\_\_\_\_ What type? \_\_\_\_\_\_ How often? \_\_\_\_\_\_  
Do you drink any “energy drinks”? \_\_\_\_\_ Which ones? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink coffee? \_\_\_\_\_Do you use sugar? \_\_\_\_ Artificial sweetener? \_\_\_\_ Creamer? \_\_\_\_  
Do you crave Sweets/Desserts \_\_\_\_\_

Do you crave Chips/Salty snacks \_\_\_\_\_

Are you tracking your food currently: \_\_\_\_\_ Have you tracked in the past? \_\_\_\_   
How? (for example, on paper, or using MyFitnessPal.com or other app) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any food allergies or dietary restrictions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Difficult areas in diet:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Difficult areas in exercise:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEHAVIOR:**

What are some things that you feel have caused you challenges/difficulties in your previous attempts at   
weight loss?   
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are some things that have helped in the past? (for example, writing down everything you ate,   
using meal replacements/shakes, using an appetite suppressant, having weekly weigh-ins?)   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your usual behavior style (check the ***one*** that describes you most of the time):

\_\_\_\_ You are almost always calm and easygoing  
\_\_\_\_ You are usually calm but occasionally impatient

\_\_\_\_ You are sometimes calm but often impatient

\_\_\_\_ You are rarely calm and find it hard to relax

Do you feel you are currently undergoing a stressful situation/ emotional upset? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Do you have a previous history of stress, anxiety or depression requiring medication, counseling, or hospitalization? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP:**

How many hours of sleep do you get per night? \_\_\_\_\_  
Do you wake up feeling rested? \_\_\_\_\_  
Do you snore? \_\_\_\_\_  
Have you been tested for sleep apnea (with a sleep study)? \_\_\_\_   
Have you been diagnosed with sleep apnea? \_\_\_\_\_ If yes, do you use CPAP or BiPAP? \_\_\_\_\_   
How many hours per night do you use it? \_\_\_\_\_ How many nights per week do you use it? \_\_\_\_

**REVIEW OF SYSTEMS:**

**General:**

**Do you currently have trouble with any of the following, please circle**

|  |  |  |  |
| --- | --- | --- | --- |
| Good general health lately | Fever | Chills | Night Sweats |
| Recent Weight Change | Sleep Problems | Loss of Appetite | Fatigue |

**Eyes:**

|  |  |
| --- | --- |
| Vision Difficulty | Concerns About Eyes |

**Ear/ Nose/ Throat:**

|  |  |  |
| --- | --- | --- |
| Hearing Difficulty | Sinus Problems | Nose or Throat Concerns |

**Musculoskeletal:**

|  |  |  |  |
| --- | --- | --- | --- |
| Joint Pain | Joint Stiffness/Swelling | Muscle Pain | Back Pain |

**Skin:**

|  |  |  |  |
| --- | --- | --- | --- |
| Rash | Itching | Suspicious Lesions/Spots | Hair Loss |

**Genitourinary:**

|  |  |  |  |
| --- | --- | --- | --- |
| Sexual Difficulty or Concern | Frequent Urination | Burning or Painful Urination | Blood in Urine |
| Incontinence or Dribbling | Trouble Initiating Stream | Weak Urine Stream | Do you still have a Menstrual Cycle |
| Breast Pain or Discharge | Hot Flashes | Irregular Menstrual Cycle | **Age at time of last menstrual cycle\_\_\_\_\_\_** |

**Cardiovascular:**

|  |  |  |  |
| --- | --- | --- | --- |
| Chest Pain | Palpitations/Irregular Heart Beat | Shortness of Breath Lying Flat | Swelling of Legs |

**Respiratory:**

|  |  |  |  |
| --- | --- | --- | --- |
| Frequent Cough | Coughing Up Blood | Shortness of Breath | Wheezing |

**Gastrointestinal:**

|  |  |  |  |
| --- | --- | --- | --- |
| Abdominal Pain or Heartburn | Change in Bowel Patterns | Blood in Stool | Black Tarry Stool |
| Nausea or Vomiting | Frequent Diarrhea | Constipation | Trouble Swallowing |

**Neurologic:**

|  |  |  |  |
| --- | --- | --- | --- |
| Frequent Headaches | Localized Weakness | Numbness | Lightheaded / Dizzy |

**Psychiatric:**

|  |  |  |  |
| --- | --- | --- | --- |
| Depression | Frequently Sad or Blue | Loss of Interest in Activities | Anxiety or Nervousness |

**Endocrine:**

|  |  |
| --- | --- |
| Excessive Thirst or Urination | Heat or Cold Intolerance |

**Hematology / Lymphatic:**

|  |  |
| --- | --- |
| Easy Bruising or Bleeding | Enlarged Glands or Lumps |

**Allergic / Immunologic:**

|  |  |  |
| --- | --- | --- |
| Hay Fever | Hives | Food Allergies  (Please List below) |

**List of Allergies:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preventive Services:**

Have you ever had the following tests? If so, when was it last done (approximate)

Mammogram Yes / No When? \_\_\_\_\_\_\_\_\_

Breast Exam Yes / No When? \_\_\_\_\_\_\_\_\_

PAP Smear Yes / No When? \_\_\_\_\_\_\_\_\_

PSA (Prostate) Yes / No When? \_\_\_\_\_\_\_\_\_

Colonoscopy Yes / No When? \_\_\_\_\_\_\_\_\_

Tetanus Shot Yes / No When? \_\_\_\_\_\_\_\_\_

Pneumonia Vaccine Yes / No When? \_\_\_\_\_\_\_\_\_

Flu Shot Yes / No When? \_\_\_\_\_\_\_\_\_

**Please answer the following questions as best as possible (thoughts and feelings):**

1. Please describe your personal journey/struggle with weight  
     
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
     
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
     
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What factors have led to your weight gain?   
     
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_