NORTHERN VIRGINIA
SURGICAL SPECIALISTS

www. novasurgery.com

432 Hospital Drive
Warrenton, VA 20186

15195 Heathcote Blvd, #240
Haymarket, VA 20169

Name:

Date of Birth:

GOALS:

What are the top 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 list weight loss programs you have done in the past 10 years:

_____

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? _____
What types of exercise have you done in the past? _____
What limits your activity now? (for example, joint pain or back pain, chest pain or shortness of breath, problems with vision, other problems) _____
Have you ever been told by a healthcare profession that you CANNOT exercise? Yes / No.

Difficult areas in exercise: _____

Please list types of exercise you are currently doing or have done in the past:

_____

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? _____
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? _____
Any history of an eating disorder (such as anorexia, bulimia, binge eating disorder)? _____

Do you drink alcohol? _____
Do you drink sodas _____
Do you drink sweet tea _____ _
Do you drink juice? _____
Do you drink any "energy drinks"? _____
Do you drink coffee? _____

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?

_____

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

_____

What factors have led to your weight gain?

_____

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? ____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need. X_____

Signature of Patient or Guardian Date