BRONSON

Bariatric and Metabolic Specialists

New Patient Paperwork

Last name: _____First name and middle initial: _____
Date of birth: _____ Social security number: _____
Home address: _____Email address: _____
Home phone: _____Work phone: _____ Cell: _____
Do you use text messages (SMS): ☐Yes ☐No
Emergency contact person: _____ Phone Number: _____
My primary doctor: _____Pharmacy name/phone Number: _____
Do you see any other healthcare providers including specialists?
If yes, please list: _____
Referring Physician:_____

Weight History:

Reason for wanting to lose weight: ☐Increased Physical Ability ☐Improve Health ☐Self Image

Current Weight: _____ lbs. Height _____ ft. _____ in. BMI_____

Have you ever seen a doctor for weight loss? ☐ Yes ☐ No
If yes, please list the doctor, when, and for how long: _____
Were you overweight as a child? ☐ Yes ☐No
How long do you feel that your weight has been a problem? _____
When in life did you weigh the most? _____ How much was your maximum weight? _____

List any medical problems, injuries, or life events that have significantly affected your weight (pregnancy, divorce, job loss, start of college)

_____

_____

History of Weight Loss Efforts:
Greatest amount of weight lost: _____Lbs. Over _____ Months.
Amount of time the loss was maintained: _____Months.
Circumstances associated with regaining the weight: _____
_____

Past Diets: Check all that you have tried to lose weight.

Name of Diet			Name of Diet	
Physician Supervised			Subway Diet	
Dietitian Supervised			High Protein	
Weight Watchers			Magazine Diet	
LA Weightloss			Detox Diet	
Jenny Craig			Raw Food Diet	
Nutrisystem			Sugar Busters	
Medifast/Optifast			Ornish Diet	
TOPS			The Cookie Diet	
Overeater's Anonymous			Self Imposed Fasting	
Richard Simmons			Diabetic Diet	
Atkins Diet			Juice Diet	
Carb Addict's			HCG Diet	
Diet Center			Belly Off Diet	
Fit for Life			Flat Belly Diet	
Gluten Free			Spark People Diet	
Mediterranean Diet			Cabbage Soup Diet	
Zone Diet			Low Fat Diet	
Liquid Protein			Low Sugar/Low Carb Diet	
South Beach Diet			Low Calorie Diet	
ABS Diet			Grapefruit Diet	
Blood Type Diet			Herbalife	

Have you ever used **over the counter** weight loss medications? (Check all that apply)

☐ Dexatrim ☐ Cortislim ☐ Relacore ☐ Lipozene

☐ Hoodia ☐ Hydroxycut ☐ Leptopril ☐ Stacker

☐ Metabolife ☐ Nanoslim ☐ Trim Spa ☐ Actislim

☐ Zovetal ☐ MuHaung ☐ Alli ☐ Green Tea Extract

☐ Sensa

Have you ever used **prescription** weight loss medications? (Check all that apply)

☐ Phentermine (Adipex) ☐ Meridia/Sibutramine ☐ Xenecal (Alli) ☐Phen/Fen

☐ Bupropion(Wellbutrin) ☐ Topamax ☐Saxenda ☐Diethylpropion

☐Phendimetrazine (Bontril) ☐ Belviq (Locaserin) ☐Qsymia (Phentermine+Topamax) ☐Contrave (Wellbutrin+Naltrexone)

What worked? _____

What didn't work? _____

Why or Why not? _____

Past Surgical History: Please list all surgeries you have had and when:

_____ _____
_____ _____
_____ _____

Have you ever had weight loss surgery? ☐ Yes ☐ No

If yes, which surgery? ☐ Laparoscopic Roux-en-Y Divided Gastric Bypass
☐ Laparoscopic Adjustable Band
☐ Laparoscopic Sleeve Gastrectomy

Your Medical History:

Do you have a history of any of the following medical conditions: (Check all that apply)

Metabolic/Endocrine

☐ Diabetes
☐Prediabetes
☐ Underactive Thyroid (Hypothyroid)
☐ Polycystic Ovary Syndrome

Sleep Disturbance

☐ Sleep apnea
☐ Do you use CPAP/BiPAP Machine?

Psychological

☐ Anxiety
☐ Depression
☐ Anorexia/Bulimia
☐ Binge Eating
☐ Night Eating

Bone/Joint

☐ Arthritis/Osteoarthritis
☐ Chronic Back Pain
☐ Chronic Knee/Hip Pain
☐ Gout

Cardiovascular

☐ Heart disease
☐ Previous Heart Attack or Stent
☐ High Blood Pressure
☐ Stroke/TIA
☐ Heart Surgery (bypass)
☐ Heart rhythm abnormalities- Atrial fibrillation, ventricular tachycardia, PVC, etc.

☐ High Cholesterol
☐ High Triglycerides

Genitourinary

☐ Urinary Stress Incontinence
☐ Kidney Stones
☐ Chronic Kidney Disease

Immune System

☐ Lupus

☐ Rheumatoid Arthritis
☐ Other Immune Disorder

Respiratory

☐ COPD/Emphysema
☐ Asthma
☐Pulmonary Embolism/Blood Clot in Lungs

For Women Only:

Age of Menarche:_____
Date of Last Menstrual Period_____
Are your periods regular? ☐ YES ☐ NO
How many times have you been pregnant? ___
How many deliveries? ___Miscarriages?_____
Abortions? _____
How many living children? _____
Sexually Active: ☐ YES ☐ NO
Contraception Type: _____
Have you reached menopause? ☐ YES ☐ NO
Date of last Gynecological Exam? _____
Date of last mammogram _____

Other

☐Migraine Headache
☐Glaucoma
☐Seizures

Gastro/Abdominal

☐ GERD/Acid Reflux
☐ Peptic Ulcer
☐ Ulcerative Colitis
☐ Crohn's Disease

Cancer

☐ What kind? _____

Please list any other past medical history that was not included above? _____
_____
_____

Medications You Are Currently Taking:

*Please include Over the Counter Meds/Vitamins/Herbs/Nutritional Supplements/Diet Aids:

Name of Medication	Dosage Strength	How Often Med is Taken

Allergies: Please include drug and food allergies:

Drug Name/Reaction	Food/Reaction

Review of Systems: Please circle if you currently have any of the following:

General	Fatigue	Always Cold	Always Hot
Heart	Chest Pain	Palpitations	Leg Swelling
Lungs	Shortness of Breath	Coughing	Wheezing
Abdomen	Nausea/Vomiting	Constipation	Diarrhea
Menstrual	Irregular Cycles	No Menstrual Cycles	Post-Menopausal
Mental Health	Depression	Anxiety	Trouble Sleeping
Skin	Hair Loss	Acne	Extra Facial Hair
Neurological	Headaches	Numbness/Tingling	Tremors
Musculoskeletal	Back Pain	Joint Pain	

Family History: (Check all that apply)

Mother:	Living: ☐Yes ☐ No	☐Cancer- Type? _____
		☐Stroke
	☐Heart Disease	☐Obesity
	☐Hypertension	☐Diabetes
Father:	Living: ☐Yes ☐ No	☐Cancer- Type? _____
		☐Stroke
	☐Heart Disease	☐Obesity
	☐Hypertension	☐Diabetes
Siblings	Living: ☐Yes ☐ No	☐Cancer- Type? _____
		☐Stroke
	☐Heart Disease	☐Obesity
	☐Hypertension	☐Diabetes

Please list any health conditions in your immediate family:_____

Current Dietary Habits:

Would you rate your current diet and eating habits as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Would you rate your current nutrition knowledge as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Would you describe your appetite as: ☐ Hearty ☐ Moderate ☐ Poor
Eat Large Portions: ☐ YES ☐ NO Eat Rapidly: ☐ YES ☐ NO Grazing: ☐ YES ☐ NO

Food preferences:

Are there foods you cannot eat? ☐ YES ☐ NO
If yes, what foods? _____
What happens when you eat this food? _____
Which foods do you have a strong dislike for? _____
Are there any strong religious or cultural influences on your eating habits? ☐ YES ☐ NO
If yes, how do they affect your eating habits or diet? _____

Portion Sizes/Servings:

Size of meat, poultry or fish serving _____ oz. Number of meat, poultry, or fish per day: _____
Number of eggs per week: _____ Servings of fruit per day: _____
Servings of vegetables per day: _____ Type of dairy products used ☐ High Fat ☐ Low Fat ☐ Non Fat
Type of bread eaten:_____ Glasses of water per day: _____

Eating Habits:

How many meals a day do you eat? _____
Do you skip meals? ☐ YES ☐ NO Do you snack? ☐ YES ☐ NO
If yes, what do you eat? _____
Who prepares your meals at home? _____
How is the food usually prepared? ☐ Baked ☐ Broiled ☐ Fried ☐Other_____
Is oil, butter or margarine used regularly for cooking? ☐ YES ☐ NO
Is salt routinely added to foods? ☐ YES ☐ NO
Are sauces used regularly? ☐ YES ☐ NO

Why do you eat? (Check all that apply)
☐ Hunger ☐ Boredom ☐ Stress ☐ Guilt ☐ Taste ☐ Depression ☐ Anger ☐ Fatigue ☐ Comfort ☐ Reward

Where in the house do you eat? _____
Do you eat while watching television? ☐ YES ☐ NO
What other activities do you do while eating? _____

Which of the following are major stresses in your life? (Check all that apply)
☐ Job ☐ Children ☐ Lack of available time ☐ Money
☐ Running a household ☐ Spouse ☐ Medical problems

How many meals each week are eaten at: Home? ____ Work? _____ Restaurants? _____

Do you pack a lunch for work or eat out? _____

When dining out:

Do you attempt to order nutritionally healthy meals? ☐ YES ☐ NO
Are you comfortable asking for special requests? ☐ YES ☐ NO

Social History:

Are you a smoker? ☐ YES ☐ NO
If yes: How many packs per day? _____ How long have you smoked? _____
If no: Have you smoked in the past? ☐ YES ☐ NO If yes, how long? _____
Do you drink alcohol? ☐ YES ☐ NO
If yes: What type of alcohol do you drink? _____
How often? _____ How much at one time? _____
Do you use or have you ever used recreational drugs? ☐ YES ☐ NO
If yes, please list_____

Fluids: How much of the following beverages do you drink daily?
Coffee_____ Diet Soda_____ Energy Drinks_____
Tea_____ Regular Soda_____

Occupation:
What is your occupation? _____

Would you describe your daily activity level as?

☐ Sedentary ☐ Light Activity ☐ Moderate Activity ☐ Heavy Activity

Family:
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Number and ages of children: _____

Who lives in your household?: _____

How would you rate your overall life satisfaction? (Please circle)

1	2	3	4	5
(Very Dissatisfied)	(Somewhat Dissatisfied)	(Satisfied)	(Somewhat Satisfied)	(Very Satisfied)

Psychological Health History:

Do you currently see a psychiatrist/psychologist/counselor or social worker regularly: ☐YES ☐NO
If yes, who? _____
Have you ever had psychological counseling for weight management? ☐ YES ☐ NO
How would you rate your self-esteem? ☐ High ☐ Fair ☐ Low

Exercise History:
Do you exercise regularly? ☐ YES ☐ NO
If yes, describe type and frequency_____
If no, why?_____
What factors interfere with exercising? ☐ Time ☐ Convenience ☐ Medical ☐ Motivation
What type of exercise do you enjoy?_____
What type of exercise do you dislike?_____
What time of day do you prefer to exercise?_____
Do you enjoy exercising alone or in a group?_____
Do you have any physical limitations or injuries that prevent certain types of exercise? ☐ YES ☐ NO
If yes, what are they and how do they affect you?_____

Sleep Apnea:

Have you ever been tested for sleep apnea?	☐ YES	☐ NO
Do you snore?	☐ YES	☐ NO
Do you ever wake up at night gasping for air?	☐ YES	☐ NO
Has anyone told you that you that you stop breathing while asleep?	☐ YES	☐ NO
Is it hard to fall asleep?	☐ YES	☐ NO
Is it hard to stay asleep?	☐ YES	☐ NO
Do you wake up tired?	☐ YES	☐ NO
Do you wake up with a headache?	☐ YES	☐ NO
Do you feel you are excessively sleepy during the day?	☐ YES	☐ NO
Do you fall asleep at work?	☐ YES	☐ NO
Do you have difficulty staying awake while driving?	☐ YES	☐ NO
Do you have difficulty staying awake while watching TV?	☐ YES	☐ NO
I work and live a night schedule and sleep during the day.	☐ YES	☐ NO

Bedtime: _____ Wake up Time: _____

Goals: What are your goals in the following areas?

	Amount of weight lost	Fitness/Health Goals
In one month	_____	_____
3 months	_____	_____
6 months	_____	_____
1 year	_____	_____
Target Weight	_____	_____

Do you feel you will be able to perform the work and have the dedication to achieve these goals?
☐ YES ☐ NO

Comments and Concerns:

Please write any concerns, questions or comments you have relating to this questionnaire, or any concerns about participating in a weight management program.

_____

_____

_____

Patient Signature: _____Date: _____

Reviewed by: _____Date: _____