Pounds for Health Medical Weight Management and Research Centre

Patient Medical History

Name: ______________________________

In regards to weight management, I am interested in receiving help with the following:

Lifestyle changes (meal plan and exercise)		Meal Replacement Program	
Medications		Surgery	
Counseling			

Please list any allergies to <u>medications</u>: **or** □ **None**

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Please list all current medications that you are taking: (you may attach a separate sheet)

Name of Medication	Strength	Frequency

Have you ever HAD or have been told you HAVE any of the following?
Please check any medical conditions that apply:

- □ High Blood Pressure
- □ High Cholesterol
- □ Diabetes: □ Type I □ Type II
  On Insulin: □ Yes □ No
- □ Coronary Artery Disease (CAD)
- □ Heart Attack; Year: _______________
- □ Heart Failure
- □ Stroke (or TIA's) Year: ____________
- □ Thyroid Disease
- □ Sleep Apnea
  □ Using CPAP machine
- □ Asthma
- □ Urinary Incontinence
- □ Osteoarthritis
  Joint(s): _________ ________
- □ Gallbladder Disease □ Removed
- □ Depression
- □ Fatty Liver

If yes, please answer questionnaire below

Symptoms:

- □ Back Pain
- □ Shortness of Breath
- □ Leg or Ankle Swelling
- □ Chest Pain / Angina
- □ Seizure (s)

Polycystic Ovarian Syndrome (PCOS) Questionnaire (Women only)
Have you ever been diagnosed with PCOS? **YES / NO**
If yes, year of diagnosis __________, treatment____________________________________

Do you have symptoms of:
- □ Infrequent, irregular or absent periods
- □ Enlarged ovaries with multiple painless cysts – as seen on an ultrasound
- □ Skin tags typically found in the armpits or neck area
- □ Darkening and thickening of the skin on the neck, groin, underarms or skin folds (also called acanthosis nigricans)
- □ Thinning hair
- □ Excess hair all over the body, including the face
- □ Acne
- □ Increased blood sugar, diabetes, or impaired glucose tolerance
- □ Infertility

Obstructive Sleep Apnea (OSA) Questionnaire
- □ Obstructive Sleep Apnea
- □ Do you snore loudly?
- □ Have you ever been told that you stop breathing, or have pauses in breathing during the night?
- □ When you wake up do you feel fatigued (tired)?
- □ Do you fall asleep easily during the day?

Other Medical Conditions: (Please note if any)

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Operations and Hospitalizations:
- □ Gastric Bypass Surgery Year: __________
- □ Cholecystectomy (Gallbladder removal) Year: __________
- □ Abdominoplasty (Tummy Tuck) Year: __________
- □ Coronary Artery Bypass Graft (CABG) Year: __________
- □ Orthopedic Surgery (Knee/Hip) Year: __________

Please add any additional surgeries in the space below:

Date	Surgery or Procedure

Family History:
Please check all that apply in regards to your family members (Grandparents, parents, siblings, children):

Overweight/Obese: □ High Blood Pressure: □

Heart Attack: □

Stroke: □

Smoking:
Current: □ Quit: □ Year:______________________________ Never: □

Alcohol Use:
Yes: □ Drinks/Day or Month:________________________ No: □

Weight History

	YES	NO
Was there an event triggering weight gain? (Pregnancy, injury, arthritis, medications?)		

What was your maximum weight since age 18? (not counting pregnancies)	

What was your lowest weight since age 18?	

	YES	NO
Are you currently exercising?		

Have you tried any of the following methods in attempts to lose weight?

Self-directed diet	
Diet Book (Atkins, South Beach, Dr. Phil etc.)	
Structured Program (Weight Watchers, Jenny Craig, etc.)	

	YES	NO
How often and what activity?		
How many meals do you eat per day?		
What do you like to snack on?		
Do you have problems with portion control?		
Are you an emotional eater?		
Do you feel hungry after a meal?		
Do you wake up at night to eat?		
My weaknesses for foods include:		