



Nutritional Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ Driver's License (State/Number/Expiration): _____

E-Mail Address: _____ May we contact you via E-Mail? YES NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): Married Divorced Widow Living with Partner Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

How does your weight affect your life and health? _____

Weight History

When did you become overweight? Childhood Teens Adulthood Pregnancy Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____

As best you can remember, how much did you weigh one year ago? _____

Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):

- Stress Marriage Divorce Illness Medication abuse Travel Injury
 Nightshift work Insomnia Quitting (circle all that apply): Smoking / Alcohol / Drugs



Previous weight-loss programs (check all that apply):

- | | | | | |
|--|---|--------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Nutrisystem | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> LA Weight Loss | <input type="checkbox"/> Atkins |
| <input type="checkbox"/> South Beach | <input type="checkbox"/> Zone diet | <input type="checkbox"/> Medifast | <input type="checkbox"/> Dash diet | <input type="checkbox"/> Paleo diet |
| <input type="checkbox"/> HCG diet | <input type="checkbox"/> Mediterranean diet | <input type="checkbox"/> Ornish diet | <input type="checkbox"/> Other: _____ | |

What was your maximum weight loss? _____

What are your greatest challenges with dieting? _____

Have you ever taken medication to lose weight? (check all that apply):

- | | | | |
|--|----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Phentermine (Adipex) | <input type="checkbox"/> Meridia | <input type="checkbox"/> Xenecal/Alli | <input type="checkbox"/> Phen/Fen |
| <input type="checkbox"/> Phendimetrazine (Bontril) | <input type="checkbox"/> Topamax | <input type="checkbox"/> Saxenda | <input type="checkbox"/> Diethylpropion |
| <input type="checkbox"/> Bupropion (Wellbutrin) | <input type="checkbox"/> Belviq | <input type="checkbox"/> Qsymia | <input type="checkbox"/> Contrave |

Other: _____

What worked? _____

What didn't work? _____

Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____: _____ a.m.

Number of times you eat per day: _____

Do you get up at night to eat? Y / N If so, how often? _____ times

Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____

Sweet beverages (check all that apply):

- Soda Juice Sweet tea Coffee/tea If so, how many times per day? _____

Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____

Eating triggers (check all that apply):

- | | | | | | |
|------------------------------------|---------------------------------------|--------------------------------|---|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Boredom | <input type="checkbox"/> Anger | <input type="checkbox"/> Seeking Reward | <input type="checkbox"/> Parties | <input type="checkbox"/> Eating Out |
| <input type="checkbox"/> Fast Food | <input type="checkbox"/> Other: _____ | | | | |

Food cravings: Sugar Chocolate Starches Salty High Fat Large Portions

Favorite foods: _____

Medical History

Exercise type: _____

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising? _____



How many hours do you sleep per night? _____ How times do you get up during the night? _____

Do you feel rested in the morning? Yes No Explain: _____

Past medical history (check all that apply):

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Angina | <input type="checkbox"/> Gall bladder stones | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Indigestion/reflux arthritis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Gout | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Syndrome | | |
- Cancer (type/s): _____

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

- Gastric bypass Gastric banding Gastric sleeve Gall bladder Heart bypass Hysterectomy
- Other: _____

Medications (list all current medications and dosages):

Allergies: (Medications) _____

Allergies: (Food) _____

Social History

- Smoking: Never Current smoker (_____ packs/day) Past smoker (quit _____ years ago)
- Alcohol: Never Occasional Regularly (_____ drinks per day)

Prior treatment for alcoholism? Y / N

- Drugs: Never Current Past Type of drugs: _____
- Marijuana: Never Current user (_____ times/day)

Family History

Obesity (check all that apply): Mother Father Sister Brother Daughter Son

Diabetes (check all that apply): Mother Father Sister Brother Daughter Son

Other (check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High triglycerides |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer (type/s): _____ | |

Other: _____



Gynecologic History

Age periods started: _____ Age periods ended _____ Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of 1st pregnancy: _____ Age of last pregnancy: _____

System Review (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Recent weight loss more than 10 pounds | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Recent weight gain more than 10 pounds | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty breathing when flat |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling ankles/extremities |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fainting/Blacking out | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Dysphagia/difficulty swallowing |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Gas and bloating |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Slow urine flow | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Back pain (upper) |
| <input type="checkbox"/> Urinary frequency/urgency | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle aches/pain |
| <input type="checkbox"/> Loss of urine control | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back pain (lower) | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Inability to concentrate |
| <input type="checkbox"/> Weakness/low energy | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of interest |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Hair changes |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fatigue/tiredness |
| <input type="checkbox"/> Cold intolerance | | |
| <input type="checkbox"/> Heat intolerance | | |
| <input type="checkbox"/> Snoring | | |

Men only: (check all that apply)

- Difficulty with erections
- Loss of interest in sex
- Low testosterone

Women only: (check all that apply)

- Absence of periods
- Hot flashes
- Change in bladder habits
- Abnormal/excessive menstruation
- Facial hair
- Loss of interest in sex
- Difficulty getting pregnant



PLAN: (PROVIDER SECTION ONLY)

Nutrition: Low-calorie diet Modified low-calorie diet Ketogenic diet
 1,000-calorie diet Maintenance Refer to RD/nutritionist

FITTE: Cardio Resistance exercises
 ACSM recommendations (150 minutes/week in active weight loss)

Behavior: Motivational interviewing performed Referral for counseling
 Discussed strategies to overcome habits/challenges for focus

Medications: Phentermine _____ mg as directed _____ # _____ RX/dispensed
 Diethylpropion _____ mg as directed _____ # _____ RX/dispensed
 Phendimetrazine _____ mg as directed _____ # _____ RX/dispensed
 Glucophage _____ mg as directed _____ # _____ RX/dispensed
 Qsymia _____
 Contrave 2 tabs BID #120 OR Contrave titrate as directed #70
 Belviq 10mg BID #60
 Saxenda 3mg (18mg/3ml) #5 pens/month supply. Novo Fine needles box of 100 use as directed.
Titrate weekly as directed until maximum dosage of 3.0mg
 Other: _____

Reviewed:

Nutrition and the importance of regular protein intake
 Labs ordered: A1C FBS Lipids TSH/TFT CMP LFT
 Hidden CHO/carbohydrate sources
 Alcohol as possible source of hidden/amenia calories and its effects
 Importance of physical activity and reducing sedentary time
 Treatment plan
 Reviewed that use of phentermine/diethylpropion/phendimetrazine for more than 90 days is considered off-label
 RTO: _____ weeks

Comments: _____

Provider's Signature: _____ Date: _____



HIPAA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

What we have adopted:

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
- Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider.
- Your confidential information will be used for the purposes of marketing or advertising of products, goods or services with your consent only.
- We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Name

Signature

Date