Family First WELLNESS

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: _____

Preferred Pharmacy (phone & location):_____Phone: _____

Other Preferred Pharmacy (phone & location):_____Phone: _____

Optional Pharmacy (phone & location): The Woodlands Compounding Pharmacy/Phone: 281-419-1340 /Fax: 281-419-2181_____

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

In the event we cannot contact you by the mean's 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

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

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ 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):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ 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):

☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ 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? _____

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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):

☐ Heart attack	☐ Angina	☐ Gall bladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux arthritis	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ 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):

☐ High blood pressure	☐ Heart disease	☐ High cholesterol	☐ High triglycerides
☐ Stroke	☐ Thyroid problems	☐ Anxiety	☐ Depression
☐ Bipolar disorder	☐ Alcoholism	☐ 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)

☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds

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

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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/amnesia 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**