



Broadway Family Clinic Cosmetics

Today's Date: _____

Name: (First) _____ (Last) _____

Date of Birth: _____ / _____ / _____

WEIGHT HISTORY

1. At what age did weight first become a problem for you?

- Childhood Teens Adulthood Pregnancy Menopause

2. Have there been any circumstances or life events that have triggered weight gain for you?

- Pregnancy Job change New medication Stress Boredom
 Marriage Divorce Illness Injury Abuse
 Alcohol Nightshift work Travel Quitting smoking
 New medication: _____ Other: _____

3. What was your weight one year ago? _____ lbs Two years ago? _____ lbs Five years ago? _____ lbs

4. What has been your highest weight? _____ lbs

5. What was your weight around age 20? _____ lbs

6. During the past 6 months my weight has: increased by _____ lbs decreased by _____ lbs been relatively the same

7. Have you lost weight with weight loss programs or diet plans in the past? If so, select from the list the program/method. (*check all that apply*):

- Weight Watchers Nutrisystem Jenny Craig LA Weight Loss
 Atkins Keto diet South Beach Zone diet
 Medifast Dash diet Paleo diet Mediterranean diet
 Ornish diet Intermittent Fasting Time restricted eating
 Other: _____

8. Have you ever used any prescription medications for weight loss? (*check all that apply*):

- Phentermine (Adipex) Meridia Xenecal/Alli Phen/Fen
 Phendimetrazine (Bontril) Topamax Saxenda Diethylpropion
 Bupropion (Wellbutrin) Belviq Qsymia Contrave
 Wegovy Other (including supplements): _____

If so, how much weight did you lose with the medication, and did you experience any side effects?

9. Have you ever had bariatric surgery? Yes No

a. If yes, please list the procedure(s) and year(s). _____

b. Are you currently interested in considering bariatric surgery? Yes No

c. Have you ever consulted a surgeon regarding bariatric surgery? Yes No

10. What do you consider some of your barriers when it comes to managing your weight? *(check all that apply)*
- Hunger Cravings Fatigue Finances
 Time Knowledge Other _____

11. How is your weight affecting your health and your life? _____

12. How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which 1 = not motivated and 10 = greatest motivation you've ever had. Your number is _____.

13. Why do you want to lose weight right now, as compared to 1 year ago? What has prompted you to lose weight now? _____

14. What are your goals/anticipated outcomes from this program? _____

★ 15. What is the **single most important thing** that you hope to achieve as a result of losing weight?

16. People who want to achieve long-term weight control need to spend at least 30 minutes a day, for a minimum of 6 months trying to change their eating, exercise, and thinking habits.

Please check the number below that best describes you:

1. I definitely **will not** be able to devote 30 minutes daily to weight control.
 2. I'm not sure if I can find 30 minutes daily for weight control.
 3. I think I can probably find 30 minutes daily for weight control.
 4. I can **definitely** find 30 minutes daily for weight control.
 5. I can devote more than 30 minutes daily to weight control

17. Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10, in which 1 = not at all confident and 10 = extremely confident. Your number is _____.

NUTRITION

1. How do you feel about your current eating habits?

- Could be better Pretty good overall but room for improvement I have great habits

2. Are you currently following a particular eating plan? Yes No. If yes, which one?

- Low fat Low carb Keto Mediterranean

Vegetarian/Vegan Intermittent fasting Other _____

3. Number of meals and snacks you eat on an average day:

- 3 3-5 6-8 8-10+

4. Food allergies / intolerances *(check all that apply)*:

- Gluten Dairy Tree nuts Eggs Soy Fish / Shellfish

Other: _____

5. Who does the most of the cooking and/or grocery shopping at your house?

- Self Spouse/Partner Other member of household Other

6. Food preferences including ethical or cultural considerations: _____

7. During a typical week, how many meals do you eat at a fast-food restaurant (including drive-thru and convenience stores)?

Breakfast _____meals a week Lunch _____meals a week Dinner _____meals a week

8. During a typical week, how many meals do you eat at or get take-out from traditional restaurant, coffee shop, cafeteria, or similar establishment?

Breakfast _____meals a week Lunch _____meals a week Dinner _____meals a week

9. How much water do you drink per day on average? _____ounces

10. Do you drink caloric beverages such as soda, juice, sweetened tea, or coffee with creamer or sugar?

Yes No. If yes, what kind(s)? _____

How many ounces per day on average? _____

11. Do you drink alcohol? Yes No. If yes, what kind? (*check all that apply*)

Beer Wine Liquor Cocktails

12. How many alcoholic drinks per week do you drink per week?

None 1-3 drinks 4-7 drinks more than 8 drinks

13. Are you frequently hungry? Yes No

14. Do you feel full after meals? Yes No

15. How soon after the last meal do you feel hungry? _____

16. Do you have cravings for certain types of foods (sweet, savory, salty, crunchy)? Yes No

17. How well are your cravings controlled? poorly controlled moderately controlled well controlled

18. Triggers for eating (*check all that apply*):

Hunger Stress Boredom Cravings Emotions

Time of day Socializing Eating out Seeking reward Insomnia

Other _____

19. Barriers to eating healthy (*check all that apply*):

Cooking skills Financial reasons Access to healthy foods Time

Schedule Home circumstances Work circumstances Other _____

NUTRITION HISTORY

Please list your food and beverage intake for the past 24 hours.

TIME	FOOD & BEVERAGES CONSUMED	PLACE CONSUMED

EATING PATTERNS

1. What is your usual eating pattern?
 - Varies from day-to-day Varies/week vs weekend Grazer No pattern/random
 - Night-time eating 3 meals per day Skip meals 3 meals plus snacks

2. During the past 3 months, did you have any episodes of eating unusually large amount of food within a 2-hour period? Yes No

IF NO, SKIP TO QUESTION 3 in this section

 - A. If yes, during the times when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating? Yes No
 - B. On average, how many days has this occurred in the past 3 months?
 - Less than 1 day/week 1 day/week 2-3 days/week 4-5 days/week nearly every day
 - C. Did you usually have the following experience during these occasions? (Check all that apply)
 - Eating more rapidly than usual
 - Eating until you felt uncomfortably full
 - Eating large amounts of food when you didn't feel physically hungry
 - Eating alone because you were embarrassed by how much you were eating
 - Feeling disgusted, depressed, or very guilty after overeating
 - D. Would other people objectively consider this an unusually large amount of food? Yes No

3. During the past 3 months...
 - A. Have you made yourself vomit as a means to control your weight? Yes No
 - B. Have you taken more than twice the recommended dose of laxatives or diuretics (water pills) in order to lose or avoid gaining weight? Yes No
 - C. Have you exercised for more than one hour specifically in order to avoid gaining weight after binge eating? Yes No
 - D. Have you taken more than twice the recommended dosage of a diet pill in order to lose or avoid gaining weight? Yes No
 - E. Have you fasted (not eating anything at all for at least 24 hours) in order to avoid gaining weight after binge eating? Yes No

4. Current or past history of an eating disorder? Yes No.

If yes, please elaborate: _____

PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity?
 not at all slightly moderately greatly
2. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class?
 Never 1-2x/ week 3-4x/ week 5 or more x/week
3. How many minutes does each bout of exercise typically last?
 10 min or less 10 min - 20 min 20 min - 30 min more than 30 min
4. Type of activities you participate in regularly (*check all that apply*)
 Walking Biking Strength training Yoga
 Other _____
5. List any barriers to physical activity. (Time, joint pain, motivation, etc.) _____

6. List equipment / spaces available to you for activity.
 Gym membership stationary bike free weights walking path
 Other _____
7. What types of activities do you enjoy or have enjoyed in the past? _____

8. How many hours per day on average do you spend in front of a screen (TV, phone, computer, tablet)?
_____ hours during work. _____ hours before/after work. _____ hours on days off work.
9. Please describe your daily lifestyle activity (how active you are) by picking a number from 1 to 10, in which 1 = very sedentary and 10 = very active. Your number is _____.

SLEEP

1. How many hours of sleep do you average per night?
 Less than 5 hours 5-7 hours 7-9 hours more than 9 hours
2. Do you work a night shift or shift work? Yes No
3. Usual bedtime: _____ Usual waking time: _____
4. Do you have trouble falling asleep or staying asleep? Yes No
5. Do you feel rested after sleeping? Yes No
6. Are you tired throughout the day? Yes No
7. Do you snore? Yes No
8. Has anyone observed that you stop breathing during sleep? Yes No
9. Do you often wake up with headaches in the morning? Yes No
10. Do you take naps during the day? Yes No
11. Have you ever been evaluated for sleep apnea or other sleep related disorders? Yes No.
If yes, were you diagnosed with sleep apnea? Yes No
If yes, do you use a CPAP, BiPap or other device? _____
12. What prevents you from getting good sleep? _____

OCCUPATION AND HOME LIFE

1. How many people live with you in your home? _____
2. If there are children in your home, please indicate their ages: _____
3. What is your occupation? _____
4. Highest level of education completed?
 Grammar School High School College Graduate School Are you in school now? _____
5. Do you have good social support for healthy lifestyle changes? Yes No
If so, list your "support people": _____

6. If you are currently involved in an intimate relationship (significant other)
 - a. What is this person's attitude towards your efforts to lose weight? _____
 - b. Please briefly describe what this person does either to help or hinder your efforts to lose weight.

MENTAL HEALTH

1. Is stress a major problem for you? Yes No
Rate your stress level on a scale from 1 to 10: _____
2. Do you feel like you have healthy coping mechanisms for stress? Yes No
How do you cope with your stress? _____
3. Do you consider yourself an "emotional eater"? Yes No
4. Do you ever feel depressed? Yes No
5. Have you ever been diagnosed with a mental health condition? Yes No
If yes, which mental health condition? Anxiety Depression Bipolar disorder
Other _____
6. Have you ever seriously thought about hurting yourself? Yes No
7. Have you ever attempted suicide? Yes No
8. Have you ever been to a counselor or other mental health professional? Yes No
If yes, are you currently receiving counseling? _____

ALCOHOL / TOBACCO

1. Alcohol usage: None Occasional Regularly (____drinks/day)
If yes, are you concerned about the amount you drink? Yes No
Have you had prior treatment for alcoholism? Yes No
2. Smoking / E-cigarettes usage: Never Current smoker Former smoker
2a. If you are a current or past smoker, how many packs/day? _____ For how many years? _____
3. Drug usage: None Current Past Type of drugs: _____
4. Marijuana: Never Current user (____times/day)

REVIEW OF SYSTEMS

Check all that apply

General

- Recent weight gain more than 10 lbs
- Recent weight loss more than 10 lbs
- Fever
- Fatigue
- Daytime sleepiness
- Chronic pain

HEENT

- Blurry vision
- Double vision
- Hoarse voice
- Snoring

Endocrine

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive hunger
- Excessive sweating
- Frequent urination

Cardiovascular/Respiratory

- Chest pain
- Palpitations
- Abnormal heart rhythm
- Shortness of breath
- Cough
- Wheezing
- Blood Clots
- Fainting/blacking out

Gastrointestinal

- Abdominal pain
- Acid reflux
- Difficulty swallowing
- Bowel irregularity
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Bloating
- Blood in stools

Genitourinary

- Incontinence
- Frequent urination
- Infertility
- Sexual difficulties
- Nighttime urination

Extremities

- Joint pain
- Muscle aches/pain
- Back pain
- Mobility issues
- Swelling in legs/ankles
- Gout

Neurologic

- Headaches
- Balance issues
- Coordination issues
- Dizziness
- Numbness
- Local weakness
- Seizures
- Memory loss

Psychiatric

- Anxious/nervous
- Depressed mood
- High stress level
- Sleep problems
- Insomnia
- Suicidal thoughts
- Mood changes
- Loss of interest

Skin

- Hair loss
- Acne
- Skin tags
- Striae (stretch marks)
- Excess skin
- Intertrigo (inflammation between skin folds)
- Skin rash

WOMEN ONLY

1. Age at onset of menstruation: _____
2. Date of last menstruation: _____
3. Do you have any of the following: heavy periods, irregularity, spotting, pain, or discharge? Yes No
4. Number of pregnancies _____. Number of live births _____.
5. Age of first pregnancy _____. Age of last pregnancy _____.
6. Pregnancy impact on weight:

	<u>1st pregnancy</u>	<u>2nd preg.</u>	<u>3rd preg.</u>	<u>4th preg.</u>
a. What was your weight at the start of your pregnancy?	_____ lbs	_____ lbs	_____ lbs	_____ lbs
b. What was your weight at delivery?	_____ lbs	_____ lbs	_____ lbs	_____ lbs
c. What was your lowest weight after delivery?	_____ lbs	_____ lbs	_____ lbs	_____ lbs
7. Did you have any pregnancy complications (gestational diabetes, preeclampsia, etc)? Yes No
If yes, please list: _____
8. Are you currently pregnant or breastfeeding? Yes No
9. Are you planning a pregnancy within the next year? Yes No
10. Are you currently using a form of birth control? Yes No type? _____
11. Do you have any problems with urinary or bladder control? Yes No
12. Have you ever been diagnosed with PCOS? Yes No
13. Have you been affected by infertility? Yes No

MEN ONLY

1. Do you usually get up to urinate during the night? Yes No

If yes, number of times: _____

2. Have you ever been diagnosed with erectile dysfunction? Yes No

3. Have you ever been diagnosed with low testosterone? Yes No

MEDICAL HISTORY

Have you ever been diagnosed with any of the following? *(please check all that apply)*

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Chronic Kidney disease |
| <input type="checkbox"/> Hyperlipidemia (high cholesterol) | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Autoimmune disorder |
| <input type="checkbox"/> Diabetes (high blood sugar) | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pseudotumor cerebri |
| <input type="checkbox"/> Prediabetes/ Insulin Resistance | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cushing's syndrome |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Irritable Bowel syndrome | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Hernia | <input type="checkbox"/> COPD/Emphysema |
| <input type="checkbox"/> PCOS (Polycystic Ovarian Syndrome) | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Metabolic syndrome | <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Fatty Liver disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Eating disorder: _____ | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Lipidema | <input type="checkbox"/> Vitamin deficiency <i>(please specify)</i> : _____ | |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Abnormal heart rhythm |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart valve disease |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Pacemaker implanted | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Primary Pulmonary Hypertension | <input type="checkbox"/> Medullar Thyroid Cancer | <input type="checkbox"/> MEN Type 2 |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Other Medical Conditions: _____ | | |

SURGICAL HISTORY

Please list surgery type and year:

MEDICATION ALLERGIES

Please list any medication allergies and your response:

ADDITIONAL INFORMATION

Please use this space to provide any additional information that you think is important to understanding you or your weight problem, as well as the goals you seek.
