

Washington Center for Weight Management & Research

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**Board Certified Endocrinology, Diabetes & Metabolism
Board Certified Internal Medicine**

Health History

We need to ask you some questions regarding confidential information about your medical history and present medical conditions. All information collected will be kept confidential. If you are not comfortable with any of the questions, please leave that question blank, and discuss the area with someone on the medical team. These records are accessible only to our research/clinical staff and will not be shared with anyone else without your permission.

Date of Birth: _____ Age: _____ Sex: M / F Racial/Ethnic group: _____

Marital Status: _____ Occupation: _____

Work Status: Full-time / Part-time / Retired / Disabled / Seeking Employment / Student / Not Seeking Employment

Hours worked per week: _____ Average number of days per months you travel for work: _____

Do you see your physician on a regular basis? Y / N Date of last physician visit: _____

Please indicate for the following:

	<u>Date of last test</u>	<u>Were results normal? Y / N - if No, explain and give dates</u>
Cholesterol		
Blood Sugar		
Flexible Sigmoidoscopy		
Colonoscopy		
Ophthalmic Exam		
Mammogram		
PAP		
Prostate Exam		
PSA		

Are you sexually active? Y / N If so, which method of birth control are you using? _____

Women Only:

How many times have you been pregnant? _____

Of these, how many were: Live Births: _____ Miscarriages: _____ Abortions: _____

Are you still menstruating? Y / N If not, when did they stop? _____

If so, are you *currently* menstruating: Y / N Date of last (most recent) menstrual period: _____

Are your periods regular (21-35 days)? Y / N Heavy? Y / N Other: _____

Do you perform a monthly self breast exam? Y / N Do you have any breast problems? Y / N

Nipple discharge? Y / N Pain? Y / N Fibrocystic change? Y / N Have you had a breast biopsy? Y / N

Have you <u>ever</u> had any of the following? (Circle all that apply)	Is this current?	Start / Stop Date	Indicate medications used for each condition circled	Dose / Frequency	Start / Stop Date
Heart disease heart attack, murmur, rhythm problems, stent, bypass					
Chest pressure , pain, tightness or shortness of breath on exertion or with normal activity					
High blood pressure , swelling in legs (edema)					
Stroke , TIAs, fainting, dizziness, syncope					
High Cholesterol , abnormal triglycerides, high LDL, low HDL					
Diabetes , pre-diabetes, glucose intolerance, insulin resistance, gestational					
Thyroid problems , hypothyroid, hyperthyroid, goiter, nodules, cold/heat intolerance					
Gall bladder disease , gallstones					
Liver disease , fatty liver, elevated liver tests, hepatitis, cirrhosis					
Lower GI problems colitis, irritable bowel, constipation, diarrhea, hemorrhoids					
Upper GI problems , reflux, hiatal hernia, ulcers, indigestion					
Breathing problems , asthma, bronchitis, emphysema, chronic cough					
Allergies , chronic sinusitis, seasonal allergies					
Skin conditions , acne, psoriasis, dermatitis, eczema, dry skin, rash, change in moles					
Osteoporosis , osteopenia, decreased bone density					
Back problems , pain, sciatica, herniated discs, spinal stenosis, back strain					
Joint problems , arthritis, replacements, gout, pain, stiffness					
Depression , mania, bipolar disorder					

Have you ever had any of the following? (Circle all that apply)	Is this current?	Start / Stop Date	Indicate medications used for each condition circled	Dose / Frequency	Start / Stop Date
Anxiety , panic attacks, PTSD, social anxiety, phobias					
Eating disorders , bulimia, anorexia, binge eating, night eating					
Alcohol or drug dependence, abuse					
Sleep disorders , insomnia, sleep apnea (CPAP?), snoring, sleep walking					
Headaches , migraines, sinus, tension, cluster					
Muscle weakness , numbness, poor coordination, tremor, fibromyalgia					
Seizures , febrile seizures, head injury					
Blood disorders , anemia, clotting problems, low WBC, clots in legs, easy bruising					
Cancer Type:					
Menstrual abnormalities , infrequent or heavy periods, fibroids, endometriosis, PCOS, PMS					
Urinary tract infections, frequency or pain on urination, kidney stones, blood in urine, incontinence					
Menopause , decrease libido, infertility, cervical dysplasia, abnormal pap					
Prostate problems , erectile dysfunction, decreased libido, infertility, abnormal urinary flow					
Vision changes , glaucoma, cataracts, blurred vision					
Hearing problems , ringing in ears, hearing loss, deaf, hearing aid					
Other:					
Surgeries , biopsies: (specify below)					

Hospitalizations (indicate reasons)	Start / Stop Date	Indicate medications used for each condition	Dose / Frequency	Start / Stop Date

All Other Medications, including anything taken over the counter, any dietary supplements, vitamins or herbs	Dose / Frequency	Start / Stop Date

Weight loss Medications, list any medications ever taken both over the counter and prescription	Dose / Frequency	Start / Stop Date

Drug Allergies, list all drugs	Describe type of reaction

Do any of your family members have or have had any of the following?	Yes	Which family member & at what age?
Obesity		
Diabetes		
High blood pressure		
High cholesterol		
Heart disease		
Stroke		
Emotional/psychiatric illness		
Alcoholism/drug addiction		
Eating disorders/bulimia/anorexia		
Thyroid disease		
Cancer		

Are both your parents and all siblings still living? Y / N

If not, please explain: _____

Number of hours **sleep** per night? _____ Do you nap? Y / N If so, average duration of a nap? ____

Do you feel rested upon awakening? Y / N Daytime sleepiness or decreased mental alertness? Y / N

Do you have difficulty sleeping? Y / N Describe: _____

Do you use sleep aids? Y / N If so, what and how often? _____ Do you snore? Y / N

Have you had a sleep study? Y / N Do you have sleep apnea? Y / N If so, do you use CPAP or Bi-pap? ____

Do you have a TV in the bedroom? Y/N

Have you ever **smoked or used tobacco products**? Y / N If yes, for how long? _____

What do/did you use? _____ How much or how many packs/day? _____

Do you currently? Y / N If **yes**, when did you start? _____ Have you ever stopped? Y / N When? _____

If no, when did you quit? _____

If you **drink alcohol** at least once a month, please estimate how much:

Wine (glasses/wk) _____ beer (cans or bottles/wk) _____ mixed drinks (per/wk) _____

Do you use recreational drugs? Y / N Have you in the past? Y / N If yes, what and when? _____

In the **last month**, have you had any of the following problems for **more than half of the days**?

Y / N Trouble falling asleep, staying asleep or sleeping too much?

Y / N Feeling tired or having little energy?

Y / N Trouble concentrating on things, such as reading the paper or watching TV?

Y / N Being so fidgety or restless that you were moving around a lot more than usual?

Y / N Feeling down, depressed, or hopeless?

Y / N Feeling bad about yourself—or that you are a failure or have let yourself or your family down?

Y / N Poor appetite or overeating?

Y / N Little interest or pleasure in doing things?

Y / N Moving or speaking so slowly that other people could have noticed?

Y / N Have you had thoughts that you would be better off dead or of hurting yourself in some way?

Y / N Being easily annoyed or irritated?

Y / N Being bothered by any muscle tension, aches or soreness?

Y / N Feeling nervous, anxious or on the edge?

Y / N Trouble falling asleep, staying asleep or sleeping too much?

Y / N In the last month, have these problems made it hard for you to do your work, take care of things at home, or getting along with other people?

Y / N In the last 6 months, have you been worrying a great deal about different things?

Y / N When you are worrying this way, do you find that you can't stop?

Y / N Do you have a history of bipolar disorder or psychosis?

Y / N Have you ever had more than one time in your life when you were depressed

(Whether or not you required treatment or therapy)?

Y / N Have you ever attempted suicide?

Y / N Has there ever been a time when you were either much more down or depressed, or had less interest or pleasure in doing things? If so, when?

Y / N Have you ever sought counseling or therapy to help you cope?

If so, type of counselor and when?

Y / N Have you ever taken medication to help with mental health problems?

If so, what did you take and when?

Present Health Status: Please rate your overall health: (circle a number)

1 2 3 4 5 6 7 8 9 10

Very Unhealthy

Very Healthy

What physical symptoms or current health problems have prompted your interest in participating in this program?

Do you see a physician for any of the symptoms or problems above?

Weight and Diet History

Please describe your typical daily diet from your first meal of the day to your last meal or snack: indicate the time you eat, the place, the specific food and beverage, the quantity and the specific restaurant or fast food.

Typical Daily Diet or 24-Hour Recall		
	Time & Place	Food & Beverage, Quantity
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

How many days per week do you **dine away** from home & at what meals? _____

What restaurants or fast food? _____

How many meals do you **eat at home** per week & what meals? _____

Who prepares the meals at home? _____ How often do you use *take out* for meals? _____

How often are prepared foods used at meals & what meals? _____

What is your **current** weight? _____ What is your weight loss goal? _____

What is the **most** you've ever weighed? _____ how old were you? _____

What is the **least** you've ever weighed in adulthood? _____ How old were you? _____

What weight do you think is **sustainable** for you? _____

Why do you want to lose weight?

Have you ever used a **medication** (prescription or over-the-counter) **for weight loss**? Y / N

If so, what and when? _____

Have you **attempted weight loss** in the past? Y / N

List the Type of Diet

Dates Followed

Indicate the Outcome

Have you used any form of **record keeping** (food, exercise, weight) in the past? Y/N What? _____

What have you learned about yourself from your prior weight loss experiences?

What are the challenges you currently face in your attempt to lose weight? _____

Do you have any food allergies? Y / N If yes, please describe: _____

Activity:

How active are you? _____ very _____ moderately _____ sedentary?

Do you enjoy being active? Y/ N If yes, what types of activity do you enjoy the most? _____

If no, do you know why? _____

Do you have any physical problems that limit your activity? Y / N

Describe _____

Have you had physical therapy for this condition? Y/N

Describe _____

Does your lifestyle incorporate activity (walk, use metro, on feet at work, etc.)? Y/ N

Describe _____

Does your activity differ during the week compared to the weekend? Y/ N In what way? _____

Do you regularly do aerobic exercise (walking, jogging, swimming, biking, etc.)? Y / N

If yes, ___sessions/week _____minutes/session

Do you regularly do muscle toning exercises (free weights, machines) Y / N

If yes, ___sessions/week

Do you regularly do stretching exercise (yoga, Pilates) Y / N

If yes, ___sessions/week _____minutes/session

If you are not yet engaged in a routine exercise program, what type of exercise would you most like to do? _____

What are your initial goals for exercise/physical activity? _____

What are your long term goals for being active?

What types of activity and how much (often) do you think are realistic and sustainable for you and your lifestyle?

Treatment Goals:

What is your **motivation** for entering this program?

What **goals** do you hope to achieve during this program?

1. _____
2. _____

To the best of my knowledge the above medical history is true:

rSignature

Date

Reviewed by

Date

