[clinic name or emblem]

WEIGHT LOSS QUESTIONNAIRE

Name: _____ Birth Date _____/_____/_____

Address: _____

City: _____ Zip: _____ Home/Cell Phone: _____ text ok ☐

Email Address: _____ Occupation: _____

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____ BMI: _____

Current Medication(s) (prescription/over the counter): _____

_____

List any medications/substances which have caused an allergic reaction: _____

_____

Pervious weight loss medication/program: _____

_____

How much weight have you gained in the past two years? _____

Family History

DISEASE/CONDITION	NO	YES
PCOS	☐	☐
Diabetes	☐	☐
Hypercholesterolemia	☐	☐
Hypertension	☐	☐
Childhood Obesity	☐	☐
Other:	☐	☐

Contraindications

DISEASE/CONDITION	NO	YES
Hx of Thyroid Cancer	☐	☐
Hx of Multiple Neoplasia 1 or 2	☐	☐
Hx of Pancreatitis	☐	☐
Current or Planned Pregnancy	☐	☐
Other:	☐	☐

Past Medical History

DISEASE/CONDITION	NO	YES	?
Obesity	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
PCOS	☐	☐	☐
Cancer	☐	☐	☐
Other:	☐	☐	☐

Past Surgical History

- ☐ Gastric Bypass
- ☐ Gastric Band
- ☐ Gastric Sleeve
- ☐ Other Non-Orthopedic Surgeries: _____

Exercise Level

- ☐ Sedentary
- ☐ Moderate
- ☐ Active

I consent to sharing the information provided here. The above information is true and correct to the best of my belief. I understand that the accuracy of this information is important and may affect medical outcomes.

Patient Signature: _____ Today's Date: _____ /_____ / _____