Weight Management Center
MOUNT AUBURN HOSPITAL
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Waltham, MA 02452
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www.weightmanagementcenter.org

# Initial Intake Questionnaire

**FORM MUST BE COMPLETED IN BLUE OR BLACK INK**

Date: _____

## Demographics

Last Name: _____ First Name: _____ Sex_____ Date of Birth: ___/___/____

Address_____
Street City State Zip Code

Telephone: Home:_____Work:_____ Cell:_____

Best Number to reach you is: (circle) HOME WORK CELL

SS# (last 4 digits only): _____ E-mail Address:_____

Emergency Contact

Name_____

Relation to You: ☐ Spouse ☐ Child ☐ Parent ☐ Friend ☐ Health Care Proxy ☐ Other: _____

Address: _____Phone:_____

Current Weight: _____ Maximum Adult Weight_____ Current Height: _____

In Which Program Are You Interested?

**Error! Bookmark not defined.**

How did you hear about Our Program: ☐ Physician ☐ A Patient ☐ Internet ☐ Other: _____

## Health Care Providers (Required Information)

**Primary Care Physician**_____

Address: _____

Phone: (___) _____ Fax: (___) _____

Mental Health Therapist/Counselor_____ Psychopharmacologist/Psychiatrist_____

Address_____Address_____

Phone: (___) _____ Fax: (___) _____ Phone: (___) _____ Fax: (___) _____

☐ Additional Providers- Please list on back of page.

**Insurance Name** (Tufts, Blue Cross, Etc.)_____

Insurance ID#_____

Name of Subscriber: _____

Relationship to Patient: ☐ Self ☐Spouse ☐ Child ☐ Other _____

Insurance Co. Address_____

## MEDICATIONS: PRESCRIPTION, OVER-THE-COUNTER, HERBS, SUPPLEMENTS, VITAMINS

Please list all medications, prescribed or non-prescribed, herbs, supplements, holistic medications, over-the-counter products.

If you take NO medications, vitamins, or otherwise, please circle: NONE

List all meds below. Continue on Back of Page if Necessary.

| MEDICATION/VITAMIN | DOSE | FREQUENCY (times per day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever used any Prescription or Over-the-Counter Medications for Weight Loss? ☐ Yes ☐ No

If Yes, Which ones? _____ _____

When? _____

**ALLERGIES**

Are you allergic to any MEDICATION? ☐ Yes ☐ No

If yes, list each medication and what happens when you use it?

Medication: Reaction:

_____

_____

_____

Are you allergic to any FOODS? ☐ Yes ☐ No

If yes, please list: _____

Please list any FOOD INTOLERANCES: _____

Are you allergic to LATEX? ☐ Yes ☐ No

Other allergies: _____

**PHARMACY** _____

Address_____

Phone: (___) _____ Fax (___) _____

**SURGERIES/OPERATIONS**

Please list all surgeries/operations you have had & their dates.

APPROX DATE: SURGERY/OPERATION: NAME OF HOSPITAL:

_____

_____

_____

_____

_____

Continue on separate page if necessary.

**HOSPITALIZATION HISTORY**

Please list all inpatient hospitalizations (including psychiatric and substance abuse treatment).

APPROX DATE: REASON: NAME OF HOSPITAL:

_____

_____

_____

_____

_____

Continue on separate page if necessary.

**FAMILY HISTORY**

Mother living YES NO Cause of death:_____

Father living YES NO Cause of death:_____

Siblings Number Living_____ Health Status:_____

Number Deceased_____ Cause of death:_____

Has anyone in your FAMILY ever had any of the following?

| | | | |
|---|---|---|---|
| OBESITY | YES | NO | Who: _____ |
| HEART ATTACK/HEART DISEASE | YES | NO | Who: _____ |
| HIGH BLOOD PRESSURE | YES | NO | Who: _____ |
| DIABETES | YES | NO | Who: _____ |
| HIGH CHOLESTEROL | YES | NO | Who: _____ |
| CANCER | YES | NO | Who: _____Type of Cancer: _____ |
| BLOOD CLOTS | YES | NO | Who: _____ |
| Other: _____ | YES | NO | Who: _____ |

**SOCIAL HISTORY**

Marital Status: Married Divorced Single Widowed Partner

Number of Children: _____ (#_____sons/#_____daughters)

Occupation: _____

Place of Employment: _____

People currently living in your household: _____

Pets:_____

**EXERCISE HISTORY**

Do you exercise? YES NO

If yes, please describe activity: _____

**ALCOHOL, TOBACCO, AND NON-PRESCRIPTION/ILLICIT DRUG USE**

**CURRENT USE:** List all alcohol, tobacco, and nonprescription drugs that you CURRENTLY use and the amounts that you use.

| | TYPE | Amount per Day | How Often Do You Use this Substance (per day/week) |
|---|---|---|---|
| ALCOHOL | | | |

TOBACCO_____
DRUGS_____

**PAST USE:** List all alcohol, tobacco, and nonprescription drugs that you have used in the PAST & the amounts that you use.

| TYPE | How often did you Use this Substance? | How long did you Use this Substance? | When did you stop Using this Substance? |
|---|---|---|---|
| ALCOHOL | | | |
| TOBACCO | | | |
| DRUGS | | | |

## MEDICAL HISTORY/REVIEW OF SYSTEMS

Circle Item if you now have or Have Ever Had any of the Following:

### GENERAL/SKIN

Do you have any FEVER NIGHT SWEATS CHILLS None
Do you feel tired all the time? YES NO
Do you have any SKIN RASH SKIN ITCHING SKIN ULCERS CELLULITIS (Skin Infection) None

### EYES, EARS, NOSE, THROAT

Do you wear GLASSES CONTACT LENSES None
Do you have DRY EYES IRRITATED EYES DOUBLE VISION LOSS OF VISION None
Do you suffer from EAR PAIN EAR DRAINAGE EAR INFECTIONS RINGING IN EARS None
Do you suffer from NOSE BLEEDS SNORING None
Do you have any DENTURES BRIDGEWORK IMPLANTS LOOSE TEETH None

### HEART AND CIRCULATION

Have you ever had CHEST PAIN CORONARY ARTERY DISEASE ANGINA
Have you ever had CONGESTIVE HEART FAILURE
Have you ever had IRREGULAR/RAPID HEART BEAT (ARRHYTHMIAS) PALPITATIONS A-FIB
Have you ever had PERIPHERAL VASCULAR DISEASE LEG SWELLING (EDEMA) PHLEBITIS
Have you ever had STROKE "MINI-STROKE"/TIA BLOOD CLOT
Have you ever had HEART VALVE DISEASE
Have you ever had HYPERTENSION/HIGH BLOOD PRESSURE LOW BLOOD PRESSURE

### LUNGS

Do you have SHORTNESS OF BREATH? YES NO
____AT REST? ___WALKING ON FLAT GROUND? ___ON STAIRS/HILLS?
Have you ever had ASTHMA BRONCHITIS COPD (EMPHYSEMA, CHRONIC BRONCHITIS)
Have you ever had PULMONARY EMBOLISM (BLOOD CLOT IN LUNG)
Have you ever had SLEEP APNEA ___CPAP Settings_____

### SLEEP QUALITY

Do you snore loudly? YES NO Unsure
Do you wake frequently at night? YES NO How many times? _____
Are you well rested after a night's sleep? YES NO

Do you wake in the morning with a headache? YES NO
Do you fall asleep unexpectedly? YES NO
How many pillows do you sleep with? _____

**ENDOCRINE**

Do you have DIABETES YES NO ___Type I (DM1) ___Type II (DM2)
Do you have INFERTILITY PCOS MENSTRUAL IRREGULARITIES
Do you have THYROID problems? YES NO ___HYPOthyroid (underactive) ___ HYPERthryoid (Overactive)
Do you get hot more easily than others do? YES NO
Do you get cold more easily that others do? YES NO
Do you have VISUAL CHANGES CHANGE IN VOICE ABNORMAL HAIR GROWTH
Do you have RECENT INCREASE IN THIRST OR URINATION YES NO

**GASTROINESTINAL/GI**

Have you ever had GASTROESOPHAGEAL REFLUX (GERD)/HEARTBURN YES NO
Have you ever had AN ULCER VOMITING BLOOD
Have you ever had CROHN'S DISEASE ULCERATIVE COLITIS
Have you ever had FREQUENT DIARRHEA FREQUENT CONSTIPATION IRRITABLE BOWEL SYNDROME (IBS)
Have you ever had GALLBLADDER PROBLEMS __GALLSTONES ___ GALLBLADDER REMOVED
Have you ever had PANCREATITIS HEPATITIS __A __B __C __ unsure
Have you ever had FATTY LIVER CIRRHOSIS
Have you ever had HEMORRHOIDS POLYPS (in colon)
Have you ever had UPPER ENDOSCOPY (EGD) When? _____ COLONOSCOPY When? _____

**HEMATOLOGY/BLOOD**

Have you ever had ANEMIA YES NO
Have you ever had IRON DEFICIENCY YES NO
Other: _____

**MUSCULOSKELETAL/BONES**

Do you have BACK PAIN YES NO
Do you have JOINT PAIN ARTHRITIS ___Osteoarthritis ___ Rheumatoid Arthritis __Joint Replacements
Do you have/ever had GOUT
Other:_____

**GENITO-URINARY**

Have you ever had KIDNEY DISEASE KIDNEY STONES
Have you ever had KIDNEY INFECTION BLADDER/URINARY INFECTION
Have you ever had LEAKING OF URINE WHEN YOU COUGH OR SNEEZE YES NO
Have you ever had PROSTATE PROBLEMS (men only) YES NO

**PSYCHIATRIC**

Have you ever had ANXIETY DISORDER YES NO
Have you ever had DEPRESSION YES NO
Have you ever had BIPOLAR DEPRESSION YES NO

Have you ever had SUICIDAL THOUGHTS YES NO

Have you ever had ANOREXIA BULIMIA BINGE EATING DISORDER LAXATIVE ABUSE

## WEIGHT AND WEIGHT LOSS HISTORY

Weight One Year Ago: _____ Estimated daily caloric Intake: _____

Are you currently at your highest weight? YES NO

What is/was your highest weight? _____

Have you ever had weight loss/bariatric surgery? YES NO If yes, type_____ When? _____

Please fill in all previous weight loss methods you have tried. List any other methods on back of page.

| DIETARY INTERVENTION | #Weeks/Months Attempted | POUNDS LOST | Length of Time Sustained Wt. Loss |
|---|---|---|---|
| Weight Watchers | | | |
| Jenny Craig | | | |
| NutriSystem | | | |
| Diet Center | | | |
| Diet Workshop | | | |
| LA Weight Loss | | | |
| TOPS | | | |
| Atkins | | | |
| South Beach Diet | | | |
| OA | | | |
| HMR | | | |
| Optifast | | | |
| Medifast | | | |
| Slimfast | | | |
| Hypnosis | | | |
| Dietitian | | | |
| Physician Supervised Program | | | |
| Behavior Therapy | | | |
| Acupuncture | | | |
| Dexatrim | | | |
| Metabolife | | | |
| TrimSpa | | | |
| Ephedra (Ma Huang) | | | |
| Other: | | | |
| **WEIGHT LOSS MEDICATIONS (Prescription/RX)** | | | |
| Phentermine | | | |
| Redux (Dexfenfluramine) | | | |
| Pondimin (fenfluramine) | | | |
| Fen-Phen | | | |
| Meridia (sibutramine) | | | |
| Xenical/Alli (orlistat) | | | |
| Other: | | | |

**How much weight do you expect to lose as a result of treatment at the Weight Management Center?**

__Less than 50 lbs. __ 50-100 lbs. __ 100-150 lbs. __More than 150 lbs.