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PRIMARY CARE
KEEPING AUSTIN HEALTHY

WEIGHT MANAGEMENT EVALUATION AND HEALTH HISTORY

PATIENT NAME: **DOB:** **AGE:**

GENDER AT BIRTH: **OCCUPATION:**

WORK HOURS: **LIST ANYONE YOU LIVE WITH:**

DATE OF LAST PHYSICAL EXAM/WELLNESS EXAM WITH LAB WORK:
**If you are currently a patient with ATX Primary Care, you may leave blank*

CURRENT PRIMARY CARE PROVIDER:

FEMALES ONLY:
ARE YOU PREGNANT?
ARE YOU TRYING TO GET PREGNANT?
LAST MENSTRUAL PERIOD?
ARE YOU ON A FORM OF BIRTH CONTROL? IF SO, WHAT TYPE?

PRESCRIPTION MEDICATIONS YOU TAKE ON A REGULAR BASIS:
**If you are currently a patient with ATX Primary Care, you may leave blank*

VITAMINS/HERBALS/SUPPLEMENTS YOU TAKE ON A REGULAR BASIS:

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

HIGH BLOOD PRESSURE	**SLEEP APNEA**
DIABETES	**"BORDERLINE" DIABETES**
THYROID PROBLEMS	**DEPRESSION OR ANXIETY**
POLYCYSTIC OVARIAN SYNDROME	**EATING DISORDER**
PANCREATITIS	**IRRITABLE BOWEL SYNDROME**
ACID REFLUX	**OSTEOARTHRITIS**

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HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:
DIABETES **THYROID CANCER**
HAVE YOU EVER SEEN A DIETITION BEFORE?

LIST ANY WEIGHT LOSS SURGERIES OR PROCEDURES YOU HAVE HAD IN THE PAST:

LIST ANY DIET / WEIGHT LOSS PLANS YOU HAVE TRIED IN THE PAST:

WHAT IS YOUR HIGHEST WEIGHT SINCE AGE 18? WHEN WAS THIS?

WHAT HAS BEEN YOUR LOWEST ADULT WEIGHT SINCE AGE 18? WHEN WAS THIS?

HAVE YOU HAD A RECENT (LAST 1 YR) WEIGHT CHANGE? HOW MANY POUNDS? LOSS OR GAIN?

WHAT AGE DID YOU BEGIN TO GAIN EXCESS WEIGHT?

WHAT DO YOU ATTRIBUTE THE GAIN TO AT THAT TIME?

WHAT IS THE MAIN REASON YOU HAVE BEEN UNABLE TO LOSE OR MAINTAIN WEIGHT LOSS?

IF YOU COULD CHANGE 2-3 THINGS ABOUT YOUR HEALTH AND NUTRITION HABITS, WHAT WOULD THEY BE?

THE BIGGEST CHALLENGE TO YOUR WEIGHT LOSS GOALS IS:

WHAT WOULD YOU LIKE TO WEIGH?

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PLEASE CHECK EVERYTHING BELOW THAT DESCRIBES YOUR EATING PATTERN OR BEHAVIORS:

	1. I eat large portions, get seconds or overfill my plate		11. I don't take time to plan healthy meals ahead
	2. I skip meals or go for longer than 5 hours between meals		12. I am tempted by family/friends to eat unhealthy foods
	3. I dine out (or get take-out) more than 3 times a week		13. I lack the knowledge to cook healthy
	4. I frequently eat fried foods, fast foods and high fat foods		14. I never feel "full" or satisfied after eating
	5. I frequently eat sweets and desserts (cookies/candy/cakes)		15. When dieting, I go to extremes
	6. I graze (snack on food all day long while doing other things)		16. I drink less than 64 oz (8 cups) of fluid (any kind) daily
	7. I eat too quickly		17. I usually drink 2 or more alcoholic drinks a day
	8. I am an emotional eater		18. My work scheduled hinders my weight loss efforts
	9. I am so busy, I forget to stop and eat		19. I would have a difficult time reducing or giving up:_____
	10. I am a "picky" eater		Anything else you want to note:

HOW MUCH SUPPORT CAN YOUR FAMILY PROVIDE?

NO SUPPORT 1 2 3 4 5 *MUCH SUPPORT*

HOW MUCH SUPPORT CAN YOUR FRIENDS PROVIDE?

NO SUPPORT 1 2 3 4 5 *MUCH SUPPORT*

ARE YOU READY FOR LIFESTLYE CHANGES TO BE A PART OF YOUR WEIGHT PROGRAM?

NOT READY 1 2 3 4 5 *VERY READY*

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LIST ANY "NON-NEGOTIABLES" WHEN IT COMES TO YOUR WEIGHT (EXAMPLE: WILL NOT GIVE UP A CERTAIN FOOD, ALCOHOL, WON'T EAT CERTAIN FOODS, ETC):

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