Medical Condition(s): Do **<u>you have any</u>** of the following medical issues/diagnoses? *(Check all that apply)*

<table>
<tr><td colspan="5">☐NONE of items below apply to me</td></tr>
<tr><td>☐High Blood Pressure</td><td>☐Coronary Heart disease</td><td>☐Osteoarthritis</td><td>☐Gallstones/ gallbladder disease</td><td>☐ Anemia</td></tr>
<tr><td>☐Polycystic ovarian syndrome (PCOS)</td><td>☐Peripheral Vascular disease (eg: stroke)</td><td>☐Urinary stress incontinence</td><td>☐Gout</td><td>☐Blood clots</td></tr>
<tr><td>☐High cholesterol</td><td>☐Fatty Liver disease</td><td>☐Acid Reflux</td><td>☐Asthma</td><td rowspan="2">☐Low sex drive</td></tr>
<tr><td>☐Obstructive Sleep Apnea
→**<u>If</u>** you have it: are you on a CPAP/BIPAP machine?
Circle One: YES NO</td><td>☐Mood disorder (**circle all that apply**:
Depression
Anxiety
Bipolar</td><td>☐ Diabetes:
Type ____ *(1 or 2)*
(Please also complete the section, on the NEXT PAGE**)**</td><td>☐Cancer: Please specify
_____
_____
_____</td></tr>
<tr><td colspan="5">☐Other (specify):</td></tr>
</table>

Diabetes History Summary:

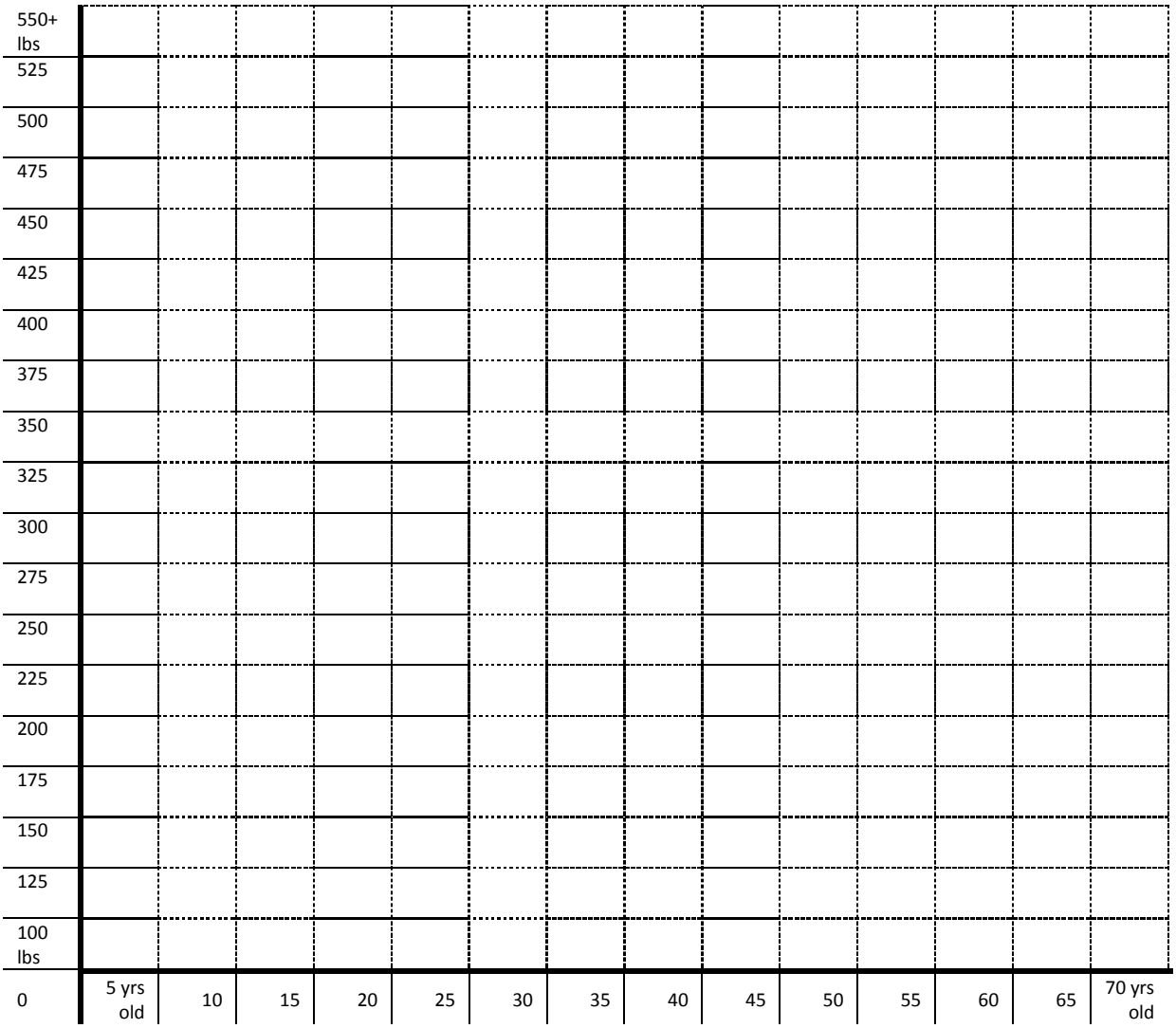
☐Not applicable, I do not have diabetes.

☐Not applicable, I have pre/borderline-diabetes

Date of diagnosis *(complete one)*	☐I was diagnosed in/on _____ *(eg: 1998 or July 2007 or on 05/23/2001)* ☐I do not remember the year but was diagnosed ~ _____ years ago			
What were the **circumstances** surrounding the diagnosis? *(check one)*	☐It was just picked up on routine labs	☐I was having symptoms (thirst, frequent urination; weight changes)	☐I was diagnosed during another medical event	☐I do not know/ remember the circumstances
Do you have any diabetes-related **complications**? *(check all that apply)*	☐No, I have none ☐Peripheral vascular disease ☐Gastroparesis	☐Eye disease (retinopathy) ☐Nerve damage (neuropathy) ☐Other (specify):	☐Foot ulcers and/or amputations ☐Kidney disease/ damage	☐Heart disease ☐Erectile dysfunction
When was your last diabetes eye exam (ie: dilated retinal exam)?	☐On _____ *(eg: on 05/23/2001)* ☐I do not remember the exact date but approximately ~ _____ *(eg: May 2013; 4-6 months ago, etc)* ☐I have never had a diabetes-eye exam ☐Many years ago			
Which diabetes **medications** have you **ever tried**/ been on?	Please list: *(eg: metformin)*			
What **medications** do you **currently** take for diabetes?	Please list:			
How **frequently** do you **check your blood sugars**? *(complete one)*	☐_____ times per day ☐_____ times per week ☐only when I am feeling symptomatic (high/low) ☐I do not check my blood sugars			
Have you had low blood sugar episodes?	☐No ☐Yes (I feel low when my sugar drops to under ___)	If yes, how frequently do you get them?	_____ times per _____ *(eg: week, month)*	What symptoms do you get when low? _____
What was your most recent hemoglobin A1c test result?			_____%	☐I don't know

Weight History

1. Weight Graph: Please **<u>place "dots"</u>** to chart your weight over the years (your best guess for ages that stand out in your memory – eg: *I was 200 lbs at age 20, 300 lbs at age 30; 250 at age 35*; etc.)



Your <u>highest</u> weight as an Adult:
⇨ _____

Your <u>lowest</u> weight as an Adult:
⇨ _____

Age(s) at marriage(s):
☐**not applicable**
1st ____
2nd ____

Weight on wedding day(s):
☐**not applicable**
1st ____
2nd ____

2. Birth Details (i.e.: <u>your</u> birth)

Birth Weight:	If known	**If NOT known**: Do you think your birth size was?:			
	_____ lbs _____ oz	☐Below Average	☐Average	☐Above average	☐Unknown
Were you delivered by?:			☐Normal Vaginal	☐C-Section	☐Unknown
Were you delivered…			☐Full Term	☐Prematurely	☐Unknown
Did <u>your mother</u> have any complications during her pregnancy with/ delivery of you? (eg: gestational diabetes)			☐Yes	☐No	☐Unknown
Did <u>you (the baby)</u> have any complications during pregnancy or due to delivery?			☐Yes	☐No	☐Unknown

3. Weight "events": Please check any of the following <u>life events</u> that you think have contributed to your weight issues. (*check all that apply*)

☐Illness/ disability	☐ Psychological event(s)	☐Pregnancy	☐Marriage ☐Divorce	☐Death of loved one(s)	☐NONE apply to me
☐Other (specify):					

Diet History

1. Diet Habit Self-Assessment: Please check any of the following <u>types of foods</u> (in the past or present) that you consume on a regular basis AND assess whether or not you think they have <u>contributed to your weight</u> issues. (*check all that apply; some overlap between answers is possible*)

Food Type Consumed	When consumed?			Contributed to weight?		Food Type Consumed	When Consumed?			Contributed to weight?	
Fast Food	☐ Never	☐ Past	☐ Present	☐yes	☐no	"Junk" food	☐ Never	☐ Past	☐ Present	☐yes	☐no
Processed foods	☐ Never	☐ Past	☐ Present	☐yes	☐no	Soda-Pop	☐ Never	☐ Past	☐ Present	☐yes	☐no
High fat foods	☐ Never	☐ Past	☐ Present	☐yes	☐no	Alcohol	☐ Never	☐ Past	☐ Present	☐yes	☐no
"Sweets"	☐ Never	☐ Past	☐ Present	☐yes	☐no	Eating Out/ Take Out	☐ Never	☐ Past	☐ Present	☐yes	☐no
"Southern cooking"	☐ Never	☐ Past	☐ Present	☐yes	☐no	High Carb- (rice breads, pasta)	☐ Never	☐ Past	☐ Present	☐yes	☐no
2nd Helpings:	☐ Never	☐ Past	☐ Present	☐yes	☐no	☐**NONE of THESE APPLY TO ME**					

2. Diet Patterns: Please check any of following <u>eating behaviors</u> that you notice yourself doing (on a regular basis). (*check all that apply*)

☐Late night eating	☐Binge eating	☐"grazing" (frequent snacking)
☐Infrequent eating (ie: eating only one meal a day)	☐Disinhibited eating (ie: lacking restraint)	☐Other (specify):

3. Eating "Triggers": Please check any of the following items that <u>trigger eating/ hunger/ cravings</u>. (*check/ complete all that apply*)

☐Type(s) of Food: (*eg: chips*)_____ _____ _____ _____ _____ _____	☐Family Issues
	☐Work Issues
	☐Illness
	☐Stress
	☐Emotions
	☐Boredom

4. Food restrictions and/or sensitivities: *Please check any/all that apply*. ☐NONE

☐Vegan	☐Lactose intolerance	☐Kosher	☐Allergy (specify):	☐Kidney/renal diet
☐ Vegetarian	☐Gluten intolerance	☐Halal	☐Warfarin restrictions	☐Other (specify):

5. Current diet summary:

Number of Meals per day (average)	⇨					
Typical portion size(s)	☐small/ below average ☐medium/ average ☐large/ above average					
Number of snacks per day (average)	⇨					
Snacking pattern	☐late night	☐ between meals	☐"grazing" (throughout day)	☐no pattern	☐other	☐I do not snack
Average number of times you eat out per week (i.e. cafeteria, take-out, delivery, restaurant, fast food)					⇨	
Do you think your current diet is:	☐Well-balanced (including fruits, vegetables and protein) ☐Imbalanced with too many/much _____ and not enough _____					
Average monthly food budget (total of meals, snacks; eating out)	☐under $300 per month		☐over $300 per month	☐Not known		
	This budget covers a family of _____ *(eg: family of 4; family of 1, etc)*					

Previous diet/ weight loss efforts:

1. "Formal" Weight programs tried: ☐Not applicable, I have never tried a formal diet program

Program (*eg: Weight Watchers*)	Initial Degree of Success in the Program (check applicable box)		
	More than 10 lbs lost (specify #). *Note: does not count weight regain*	5 – 10 lbs lost	Less than 5 lbs lost (or weight gain)
	☐ _____ lbs lost	☐	☐
	☐ _____ lbs lost	☐	☐
	☐ _____ lbs lost	☐	☐

2. Weight loss medications tried (click all that apply): ☐Not applicable, I have never tried meds for weight

☐phentermine (Adipex)	☐Orlistat (Alli, Xenical)	☐metformin (for weight)	☐Lorcaserin (Belviq)
☐Fen-Phen	☐Sibutramine (Meridia)	☐phentermine/ topiramate (Qsymia)	☐Other (specify):

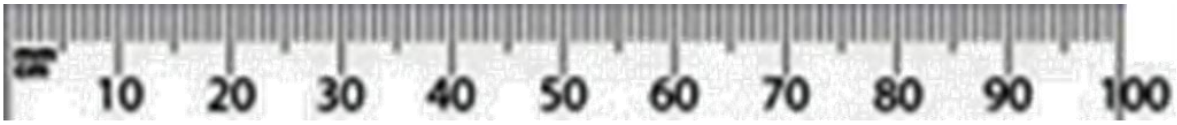
3. Have you ever had an appointment with a dietician? ☐ Yes ☐No

4. Have you ever had weight loss/ bariatric surgery?
   ☐No
   ☐Yes: ☐Roux-en-Y gastric bypass ☐sleeve gastrectomy ☐lap band ☐Other (specify): _____

Physical Activity History

1. **Historical trend:** Please use this visual analog scale to estimate the AVERAGE amount of physical activity/ exercise performed at various stages of life. Please review the scale/ interpretation and mark by the number that best fits your assessment.

Childhood



0 = no spontaneous activity/ exercise

100 = vigorous exercise/ activity on four or more days per week

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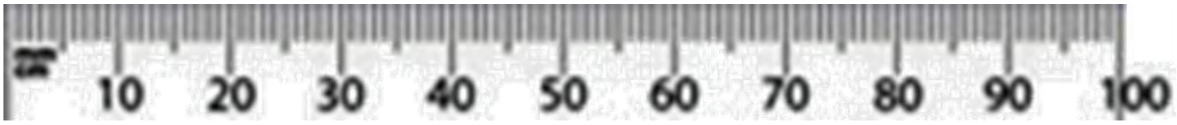
Teens



0 = no spontaneous activity/ exercise

100 = vigorous exercise/ activity on four or more days per week

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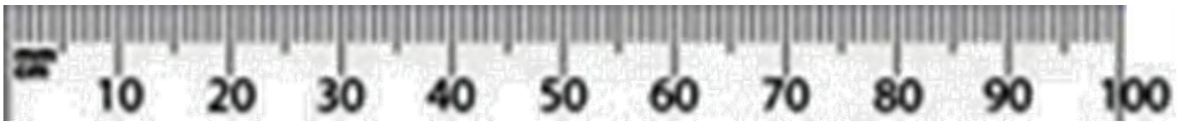
Young adulthood (age 18-30)



0 = no spontaneous activity/ exercise

100 = vigorous exercise/ activity on four or more days per week

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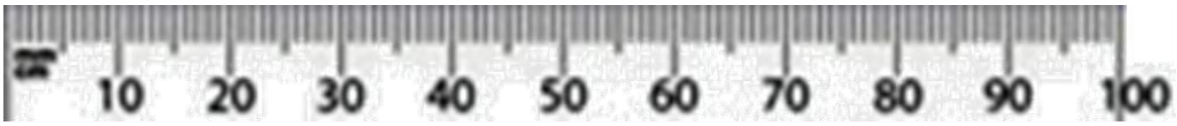
Adulthood (over age 30): ☐not applicable



0 = no spontaneous activity/ exercise

100 = vigorous exercise/ activity on four or more days per week

2. **Current exercise regimen**: ☐ Not applicable: I do not exercise, regularly

Type of exercise (*eg: walking*)	Number of times performed per week	Number of minutes per session (average)	Intensity of exercise (mild, moderate, rigorous)

Family History

Family Member	Obesity	Diabetes	Heart Disease	Cancer
Mother				
Father				
Sibling(s) (specify)				
Grandparents (specify)				
Aunts/uncles (specify)				

WOMEN ONLY:

Age of first menstrual period?	⇨

Menstrual status (check one)

☐PRE-MENOPAUSAL		☐POST-MENOPAUSAL			
What was the first day of your last menstrual period?	⇨	Age of menopause (age of last period)?	⇨	Circumstances of menopause	☐Natural ☐Hysterectomy ☐Uterine ablation
IF pre-menopausal, what is your birth control method?	☐Birth Control Pill ☐Depo-Provera ☐"Natural" family planning ☐Barrier methods (condoms, etc) ☐abstinence ☐Intrauterine device (IUD) ☐other (specify): _____				

Have you ever been pregnant? ☐Yes ☐No

If "yes":

How many times have you been pregnant?			⇨	
How many children have you delivered?			⇨_____ *(eg: 3 children)* If you have children, what were the birth weights? 1st child _____ lbs _____oz *(eg: 8 lbs ??? oz)* 2nd child _____ lbs _____oz 3rd child _____ lbs _____oz 4th child _____ lbs _____oz	
How many pregnancy losses have you had?			⇨	
What was the average amount of weight gained during your pregnancy/pregnancies?			⇨ *(eg: I gained ~30 -40 lbs)*	
Did you ever have any complications during pregnancy?	☐Yes ☐No	If yes, did you have:	☐gestational diabetes ☐Pregnancy-induced high blood pressure	☐pre/ecclampsia ☐other (specify):
Were there any fetal (baby) complications?	☐Yes ☐No	If yes, describe:	⇨	