UNIVERSITY OF MARYLAND MEDICINE

Patient label. For office use only:

PATIENT INFORMATION:

Are you being seen at the Center for Weight Management and Wellness for:

- ❑ Bariatric Surgery Evaluation
- ❑ Medical Weight Loss Program

1) Name: ____________________________

2) Date of Birth: ____________________________

3) Age: ____________________________

4) Social Security Number:________________________

5) Mailing Address: ____________________________

City, State, Zip Code _________________________

6) Phone Number: Home: ________________________

Work: ________________________

Cell: _________________________

How did you hear about the Center:

___Television
___Internet
___Another patient
___Physician
___Radio
___Other_____________________

Height: ____________

Weight:____________

7) Email Address:______________________________

8) Best way to contact you: ____cell phone ____work ____ home ____email

9) Were you referred to the Center by a doctor? ____Yes or ____ No

10) Primary Care Doctor's Information:

Name: ________________________________

Phone Number: ______________________ Fax Number:__________________

Address: ____

City, State, Zip Code: ____

11) Emergency Contact: Name: ________________________ Relationship:____________

Phone number (work) :____________________Phone number (home):___________________

12) Emergency Contact: Name: ________________________ Relationship:____________

Phone Number (work): ____________________Phone Number (home):___________________

13) Insurance Information:
Insurance Company Name:____

Address:____

Phone Number:(______)____

Policy #:_______________________ Group #:____________________ Effective Date:_______

Policy Holder's Name:____

Secondary Insurance Company Name:____

Address:____

Phone Number:(_______)____

Policy #:_________________________Group #:______________ Effective Date: __________

Medicare #:____________________________

13) Do we have your permission to email you or to leave you a message on your voicemail regarding information/results about your medical care? ____Yes or ___ No

Signature________________________________

MEDICAL PROBLEMS: (Check all that apply)

Write on back of page if you need to explain in more detail

- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Impotence/sexual dysfunction
- ❑ Liver disease
- ❑ Thyroid disease
- ❑ Heart Disease (heart attack, bypass, stent)
- ❑ Chest Pain/Angina
- ❑ High Blood Pressure
- ❑ Leg swelling/edema
- ❑ Anemia
- ❑ Gestational Diabetes
- ❑ Diabetes
- ❑ Bladder incontinence
- ❑ Gallbladder Disease
- ❑ Ulcers
- Kidney Stones
- Shortness of Breath
- ❑ Back Pain
- ❑ Snoring
- ❑ Arthritis
- Stroke/"Mini-Stroke"
- ❑ Fatigue during the day
- Gout
- Blood clot
- ❑ Reflux/heartburn
- ❑ Bowel incontinence
- ❑ Fractured bone
- ❑ Have you ever had a stress test? If yes, what year and where?________________________
- ❑ Eating disorder? If yes, what kind?__________________________
- ❑ Please list any surgeries you have had:

____

____

____

- ❑ Depression

a) If yes, did you receive treatment

- ❑ Therapy with a counselor
- ❑ Medication
- ❑ Hospitalization

- ❑ Other physical or mental illnesses or hospitalizations? Please list below. If hospitalized, please write down which hospital, why you were admitted, and the month/year.

____

____

____

____

MEDICATIONS AND DOSES (Include vitamins, herbal supplements)

Write on the back of page if you need more space

1) ________________________________ 6) ________________________________

2) ________________________________ 7) ________________________________

3) ________________________________ 8) ________________________________

4) ________________________________ 9) ________________________________

5) ________________________________ 10) ________________________________

11) ______________________________ 12) ______________________________

Do you have any allergies to any medications? Yes or No. If yes, please list the medication and explain what the reaction is (swelling, hives, rash, etc)

____

SOCIAL HISTORY

1) Do you currently smoke? ____Yes or _____No. 2) If yes, how much? _______packs/day

3) Did you ever smoke? ______Yes or ______No. If yes: When did you quit?________(year)

How many? ______________packs/day

4) Do you drink alcohol? ____Yes or _____No

5) If yes, please answer the following questions:

a)What kind of alcohol:
- ❑ wine
- ❑ liquor
- ❑ beer

b) How often?
- ___Rarely ___ 1-2 times a week ___ 3-4 times a week
- ___Daily, 1 drink a day
- ___Daily, 2-3 drinks a day
- ___Daily, 3-4 drinks a day
- ___Daily, >5 drinks a day

6) What is your occupation? ____

7) What hours do you work? ___________________________

8) How do you get to work?
- ❑ drive
- ❑ bus
- ❑ walk
- ❑ other public transportation

9) How long is your commute to work?____________________minutes

10) What is your highest level of education?
- ❑ some high school
- ❑ high school/GED
- ❑ college
- ❑ post-graduate

11) Are you:
- ❑ married If yes, does your spouse support your efforts to lose weight? ___Yes or ___ No
- ❑ single
- ❑ divorced
- ❑ widowed
- ❑ other
- ❑ living with a significant other (SO)?

If yes, does your SO support your efforts to lose weight? ____Yes or ____ No
11) Is your significant other overweight/obese? ____Yes or ____ No or____ N/A
12) Does your family support you in your efforts to lose weight? ____ Yes or ____ No
13) How many children do you have? ________________
14) Are you children overweight or obese? ____Yes or ____ No

FAMILY HISTORY

Please check any medical problems that are in your family and list which family members have this medical condition (ex. mother, grandfather, son, etc.)

Disease	Family Member (ex. mother, daughter, brother)
❑ Diabetes	____________________________
❑ Heart Attack/ Stent/ Bypass	____________________________
❑ Angina/Chest Pain	____________________________
❑ Stroke	____________________________
❑ Cancer	____________________________
❑ High Blood Pressure	____________________________
❑ High Cholesterol	____________________________
❑ Blood Clots	____________________________
❑ Kidney Stones	____________________________
❑ Osteoporosis	____________________________
❑ Thyroid Disease	____________________________

List any other medical problems in your family not listed above:

Are any of your children, siblings or parents overweight? Please list below:

WEIGHT AND DIET HISTORY

1) Current weight:________________

2) How much weight do you want to lose?_____________pounds

3) Over how much time?_________________

4) Why do you want to lose weight now? Please explain below:

5) Check the two most important factors you perceive contribute most to your weight gain?

- ❑ Metabolism/Genetics
- ❑ Binge Eating
- ❑ Depression
- ❑ Portion Sizes
- ❑ Inactivity/lack of exercise
- ❑ Medications
- ❑ Appetite/Always feeling hungry

6) Were you an overweight child (less than age 5)? ____Yes or ____No

7) Were you an overweight teenager? ____Yes or ____No

8) How old were you when you first became overweight? ______________

9) Was there any life event related to your weight gain? (example: you started to gain weight after the death of a loved one) _____Yes or ______ No. If yes, please explain:

10) How much did you weigh one month ago?__________pounds
One year ago?__________ pounds
Five years ago?__________pounds

11) What was your lowest adult weight? __________pounds Highest? _________pounds

12) Are you a yo-yo dieter (do you often intentionally lose weight but then regain it?)____Yes or___No

13) What is the most weight you have ever lost? _________pounds.
a) How did you lose that weight?

- ❑ Crash diet
- ❑ Diet change
- ❑ Exercise
- ❑ Medication
- ❑ Illness
- ❑ Surgery
- ❑ Commerical Weight Loss Program (Weight Watchers, Jenny Craig, etc)
- ❑ Other: (please explain)______________________________

b) How long did you keep it off? ______weeks

14) Please check the appropriate answer. During the last 6 months my weight has:
_________ been increasing _________been decreasing ___________been stable

FOR WOMEN ONLY:

1) Have you ever been pregnant? ____Yes _____No If no, skip this section;

First pregnancy:
-Weight at start of pregnancy:____________pounds
-Lowest weight in the first year after delivery: __________ pounds
-Did you breast-feed the baby? ____ Yes or____ No

Second pregnancy:
-Weight at start of pregnancy:____________pounds
-Lowest weight in the first year after delivery: __________ pounds
-Did you breast feed the baby? ____Yes or ____ No

Third or Last Pregnancy:
-Weight at start of pregnancy:____________pounds
-Lowest weight in the first year after delivery: __________ pounds
-Did you breast-feed the baby? ____Yes or ____ No

4) Did you develop diabetes during any of the pregnancies? ____ Yes or ____No

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Please check all supervised diets you have tried in the past

	Month/ Year	#of weeks in Program	# of pounds lost	# of pounds regained
Diet Counters				
Medifast				
Supervised calorie counting diet (dietitian or nutritionist)				
Overeaters Anonymous				
Optifast				
Weight Watchers				
Health Management Resources				
Nutri-Systems				
T.O.P.S.				
Jenny Craig				
New Direction				
National Weight Loss				
OTHER				

Please check all non-supervised diets that you have attempted in the past.

	Month/ Year	#of weeks in Program	# of pounds lost	# of pounds regained
Body for Life				
Calorie counting				
Atkins Diet				
Gloria Marshall				
Health Spas				
High protein				
Hypnosis				
Low carbohydrates				
Low fat				
Pritikin				
Richard Simmons				
Scarsdale				
Stillman diet				
Sugar Busters				
Slim-Fast				
Mayo Clinic				
Other				

Please check any medications you have tried or have been prescribed for weight loss.

	Month/ Year	#of weeks in Program	# of pounds lost	# of pounds regained
Acutrim				
Adipex-P				
Amphetamines				
Anorex				
Benzphetamine				
Bontril				
Dexatrim				
Dexfenfluramine				
Didrex				
Fastin				
Fenfluramine				
Ionamin				
Meridia				
Orlistat				
Phentermine				
Phentrol				
Plegine				
Pondimin				

Prelu-2				
Redux				
Sanorex				
Tepranol				
Tenuate				
Wehless				
Xenical				
X-Trozine				
Mazanor				
Obalan				
Phendiet				
Fen-Phen				
Other				

In your life, how many times have you tried/started a weight loss program?
____None_____1-3_____ 4-6 _____>10 ____>100 ______ Too many to count

In the past 5 years, how many times have you tried/started a weight loss program?
____None ____1-3 _____ 4-6 _____ >10 _____ >100 _____ Too many to count

EATING HISTORY

1) With whom do you live? (check all that apply)
- ❑ alone
- ❑ spouse/significant other
- ❑ roommate
- ❑ parent
- ❑ children
- ❑ other_________________

2) How many meals a week do eat in restaurants or order take out?
- ❑ none
- ❑ 1-2
- ❑ 3-4
- ❑ 5-7
- ❑ 8-10
- ❑ all of them

3) With whom do you usually eat? (check all that apply)
- ❑ alone
- ❑ spouse/significant other
- ❑ roommate
- ❑ parent
- ❑ children
- ❑ other_________________

4) Who prepares your meals? ______________________________

5) Who buys your food? ________________________________

6) Do you eat breakfast? _____Yes or_____ No

7) How many meals do you eat on a typical weekday?
- ❑ 1-2
- ❑ 3-4
- ❑ 5-7

8) How many meals do you eat on a typical weekend day?
- ❑ 1-2
- ❑ 3-4
- ❑ 5-7

9) When do you usually snack? (check all that apply)
- ❑ morning
- ❑ afternoon
- ❑ before bed
- ❑ after dinner
- ❑ middle of the night

10) How many glasses of water do you drink a day?
- ❑ none
- ❑ 1-2
- ❑ 3-4
- ❑ 5-7
- ❑ 8-10

11) How many times a day do you feel hungry?
- ❑ none
- ❑ 1-2
- ❑ 3-4
- ❑ all day

12) Do you often eat when you are NOT hungry? ____Yes or ____No

13) What types of situations encourage you to eat?
- ❑ stress
- ❑ depression
- ❑ happiness
- ❑ boredom
- ❑ other__________________

14) How often do you eat fast food?
- ❑ daily
- ❑ 2-3x's week
- ❑ once a month
- ❑ once every couple of months

- never

15) Are you a binge eater (eating a large amount of food within 1-2 hours and being unable to control the amount consumed or to stop eating)? _____Yes or ____No

16) Do you ever eat until you are so full that you are uncomfortable?
- rarely
- daily
- 1-2x's a month
- weekends
- never

17) Which eating pattern is most typical of you?
- Regular meals at regular times
- Occasionally skip a meal
- Routinely skip a meal
- Eat once a day
- Graze all day

18) How often do you eat potato chips, pretzels, Doritos, candy, cookies or similar foods with your meals?
- rarely
- once a day
- most meals
- weekends only
- never

19) Do you drink regular soda (non-diet)?
- rarely
- 1-2 x's a week
- once a day
- most meals
- weekends only
- never

20) What food do you consider "high risk"? (examples—foods that you binge on or can not stop eating once you start):

21) Have you ever received treatment for an eating disorder such as bulimia or anorexia? Yes or No. If yes, please explain in the space below:

22) Do you ever feel guilty or upset after you eat a meal? If yes, how often:

- ❑ Every day
- ❑ Once a week
- ❑ Once a month
- ❑ Rarely
- ❑ Never

23) During the past 6 months, did you fast (not eat anything at all for at least 24 hours)?
Yes or No If yes, how often:

- ❑ Never
- ❑ Less than once a week
- ❑ Once a week
- ❑ 2-4 times a week
- ❑ More than 5 times a week

24) During the past 6 months, did you exercise for more than one hour specifically in order to avoid weight gain after binging?
_____ Yes or ____ No If yes, how often:

- ❑ Never
- ❑ Less than once a week
- ❑ Once a week
- ❑ 2-4 times a week
- ❑ More than 5 times a week

25) How often do you take laxatives or make yourself vomit to prevent weight gain?

- ❑ After every meal
- ❑ Every day
- ❑ Once a week
- ❑ Once a month
- ❑ Rarely
- ❑ Never

6) Do you ever wake up in the middle of the night and eat?

- ❑ rarely
- ❑ daily
- ❑ 1-2x's a month
- ❑ weekends
- ❑ never

WOMEN ONLY:

1) Does your eating behavior/cravings changed during your menstrual cycle?

- ❑ I eat much less
- ❑ I eat more
- ❑ I eat much more
- ❑ There is no change

2) Do you crave any particular food around the time of your menstrual cycle?

- ❑ Salty foods

- ❑ Sweets
- ❑ Fats
- ❑ There is no change

EATING BEHAVIORS:

Use the scale below to answer the following questions:
1= Does not describe me at all
2= Describes me a little
3=Describes me exactly

1. _____ I overeat when I am feeling angry.
2. _____ I overeat when I am feeling depressed.
3. _____ I overeat when I am feeling bored.
4. _____ I overeat when I am feeling happy or celebrating.
5. _____ When I am with others, I am one of the first to finish my meal.
6. _____ I tend to nibble when I am preparing or cleaning up a meal.
7. _____ I regularly have second helpings of food I enjoy.
8. _____ I tend to clean my entire plate even if I am fool.
9. _____ I tend to eat more when I am with certain people.
10. _____ Many of my family and friends like to do things that are centered around eating.
11. _____ I attend a lot of social events where food is served.
12. _____ My work requires that I eat out a lot.
13. _____ When I am at a party, I have trouble controlling what I eat.
14. _____ When I get urges to eat, I have a very hard time controlling them.
15. _____ I often feel guilty by the amounts of or types of food I eat.
16. _____ I overeat when I am feeling stressed or anxious.
17. _____ When I feel that I have eaten too much, I will fast, exercise, vomit or use a laxative to get rid of the excess calories.
18. _____ I rarely eat fruits and vegetables.
19. _____ I regularly eat desserts.
20. _____ I regularly eat fried foods.
21. _____I rarely steam, bake or broil my food.
22. _____ I feel like it takes too much time to eat healthy.

PHYSICAL ACTIVITY

1) Are you seated for most of the day at your job? ____ Yes or_____ No

2) How many times do you exercise a week?

- ❑ none
- ❑ 1-2
- ❑ 3-4
- ❑ 5-6
- ❑ daily

3) Describe your typical exercise regimen. For example do you walk, jog, lift weights, swim etc. and for how long do you do each activity?

4) Are you unable to exercise for any medical reason (joint pain, shortness of breath, chest pain, etc)? ____Yes or____ No

If yes, please list the reasons that you cannot exercise:

5) What is your biggest obstacle preventing you from doing regular daily exercise?

- ❑ I don't know how to start
- ❑ I hate exercise
- ❑ No time
- ❑ Pain
- ❑ Shortness of breath
- ❑ Other medical reason
- ❑ No place to do it
- ❑ No reason. I just don't.
- ❑ Other________________________

6) Does your employer encourage you to exercise or take walk breaks during the day?
___Yes or ___ No

7) Do you feel that your job contributes to your weight (for example: you are sitting at a desk all day, hours are too long for you to go exercise)?

8) If you have the choice between an elevator and stairs, which do you usually choose?
____ Elevator or _____ Stairs.

9) Are the stairwells well-marked and safe at your job? ____Yes or _____ No

10) Do you belong to a gym? If no, why: (please check all that apply)

- ❑ I cannot afford it
- ❑ There is not a gym close to where I live or work
- ❑ I am embarrassed to work out in a public gym because of my weight.
- ❑ I am afraid that if I joined a gym that I would not know how to use the equipment.
- ❑ I hate to work out in a gym.
- ❑ I never thought about it.
- ❑ Other ________________________________

11) Did you play sports as a child or as a teenager? ___Yes or ____ No. If yes, please list them.

12) Does your weight make it difficult to perform any of the following activities?

Tying your shoes _____Yes or ____ No

Using the toilet _____Yes or ____ No

Walking a flight of stairs _____Yes or ____ No

Taking a shower/bath ______Yes or ____ No

Being sexually active ______Yes or ____ No

Traveling ______ Yes or ____ No

Doing housework ______ Yes or ____ No

Holding a job ______ Yes or ____ No

13) Please list any hobbies that you might have:

Self Perception and Psychological Health—Take sections N and O from the WALI

Note: Completion of this form does not constitute a physician/patient relationship.