Medical Weight Loss Intake Form

Please fill out this form as completely and accurately as possible. This will help us understand your health status, weight loss goals, and medical needs. Thank you for choosing us as your partner in your weight loss journey.

Personal Information

Name: _____ Date of Birth: _____

Gender: □ Male □ Female □ Other

Address: _____City: _____State: _____Zip Code: _____

Phone Number: _____Email Address: _____

Emergency Contact: _____Relationship: _____Phone Number: _____

Weight Loss History

Current weight: _____ lbs Height: _____ft _____in BMI:_____

Ideal weight: _____ lbs When was the last time you were at that weight?_____

How much weight do you want to lose? _____ lbs

How long have you been trying to lose weight? _____

What are the main reasons you want to lose weight? (Check all that apply)

□ Health □ Appearance □ Self-esteem □ Fitness □ Other: _____

Did you have a:

Normal weight upon birth? □ Yes □ No
Normal weight during childhood? □ Yes □ No
Highest adult weight_____lb / Lowest adult weight_____lb Lowest

Are there any other reasons for weight gain? *Answer any that apply.*

□ Shift work with associated weight gain of_____lb
□ I quit smoking with associated weight gain of_____lb
□ Past or present medications associated with weight gain of _____lb
□ Menopause or hormonal conditions associated with weight gain of _____lb
□ Pregnancy associated with persistent weight gain of _____lb

Is there evidence of a genetic history of obesity? *Check all that apply:*

□ There is a strong family history of obesity.
□ Obesity started early and has been progressive during my life.
□ I was excessively hungry as a child.

Please describe when and how you started gaining weight.

_____
_____
_____
_____

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Have you ever tried any weight loss programs or methods? (Check all that apply)

□ Diet □ Exercise □ Medication □ Surgery □ Supplements

□ Other: _____

If yes, please list the names/dates of the programs/methods you have tried, and the results achieved:

Program / Method	**Date**	**Results**

What is the most weight that you have lost _____lb

How long did you maintain your weight loss? _____

What are the main challenges or barriers that prevent you from losing weight or maintaining weight loss? (Check all that apply)

□ Lack of motivation □ Lack of support □ Lack of time □ Stress □ Cravings

□ Emotional eating □ Binge eating □ Medications □ Hormonal issues

□ Medical conditions □ Other: _____

Medical History

Do **YOU** have any *current* or *past* medical conditions or diagnoses? (Check all that apply)

□ Diabetes □ High blood pressure □ High cholesterol □ Heart disease

□ Stroke □ Thyroid (hyper/hypo) □ Thyroid Cancer □ Kidney problems

□ Pancreatitis □ Gallbladder problems □ Liver problems □ Arthritis

□ Asthma □ Osteoporosis □ Sleep apnea □ Gastrointestinal problems

□ Anxiety □ Bipolar disorder □ Depression □ Eating disorder

□ Insomnia □ Multiple Endocrine Neoplasia (MEN) Syndrome Type 2

□ Other: _____

If yes, please provide more details about your conditions or diagnoses, such as the date of diagnosis, the severity, the treatment, and the current status:

Condition/Diagnosis	**Date**	**Severity**	**Treatment**	**Status**

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Do you have any **family history** of the following conditions or diseases? (Check all that apply)

□ Diabetes □ High blood pressure □ High cholesterol □ Heart disease

□ Stroke □ Thyroid (hyper/hypo) □ Thyroid Cancer □ Kidney problems

□ Pancreatitis □ Gallbladder problems □ Liver problems □ Arthritis

□ Asthma □ Osteoporosis □ Sleep apnea □ Gastrointestinal problems

□ Anxiety □ Bipolar disorder □ Depression □ Eating disorder

□ Insomnia □ Multiple Endocrine Neoplasia (MEN) Syndrome Type 2

□ Other: _____

If yes, please indicate which family members have or had these conditions or diseases:

Condition/Disease	**Family Member**

Do you have any allergies or sensitivities to any foods, medications, or substances? (Check all that apply)

□ Food □ Medication □ Substance □ None

If yes, please list the names and types of the foods, medications, or substances you are allergic or sensitive to, and the reactions you experience:

Food/Medication/Substance	**Type of Reaction**

Are you currently taking any prescription or over-the-counter medications, supplements, vitamins, or herbs? (Check all that apply) If yes, please list the names and dosages of the medications, supplements, vitamins, or herbs you are taking, and the reasons you are taking them:

Medication/Supplement/Vitamin/Herb	**Dose**	**Reason**

Are you currently pregnant, planning to become pregnant, or breastfeeding? (Check one)

□ Yes □ No □ Not applicable

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Lifestyle Habits

How would you describe your typical daily diet? (Check all that apply)

□ Balanced □ Low-carb □ Low-fat □ High-protein □ Paleo

□ Vegetarian □ Vegan □ Gluten-free □ Dairy-free □ Keto

□ Intermittent fasting □ Other: _____

Please write down everything you ate in the previous 24 hours starting with *yesterday morning.*
(*Please include alcohol and sugar-free beverages as well.)*

Meal	Time	Food and Drinks Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Do you have excessive hunger within 1-2 hours of having a regular meal? □ No □ Yes

Do you track your calorie intake or macronutrient ratios? (Check one) □ No □ Yes

If yes, what are your average daily calorie intake and macronutrient ratios: Calories: _____

Carbs: _____% / grams Fat: _____% / grams Protein: _____% / grams

Please list any food preferences, dislikes, or intolerances, if applicable:

_____

_____

_____

How often do you eat out or order takeout? (Check one)

□ Daily □ Weekly □ Monthly □ Rarely □ Never

How often do you drink alcohol? (Check one)

□ Daily □ Weekly □ Monthly □ Rarely □ Never

If applicable, please indicate the type / amount of alcohol you drink:_____

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How often do you smoke or use tobacco products? (Check one)

□ Daily □ Weekly □ Monthly □ Rarely □ Never

If applicable, please indicate the type / amount of tobacco products you use:_____

At times I eat when I am not hungry. □ Yes □ No

*If yes, describe when this happens and why?*_____

I eat for comfort when I am stressed or emotional. □ Yes □ No

If yes, describe when this happens and why? _____

There are times when I eat and it feels like I can't stop. □ Yes □ No

*If yes, describe when this happens and why?*_____

I try to manage my weight by vomiting, using laxatives, diuretics, or excessive exercise. □ Yes □ No

If yes, when was the last time? _____

Sometimes I find food on my bed which I do not remember eating. □ Yes □ No

*If yes, how often does this happen?*_____

I eat late at night or I wake up at night and eat. □ Yes □ No

Please list foods that you eat frequently**:**_____

_____

Physical Activity

How often do you exercise or engage in physical activity? (Check one)

□ Daily □ Weekly □ Monthly □ Rarely □ Never

If applicable, please indicate the type, duration, and intensity of your physical activity:

Type: _____

Duration: _____

Intensity: _____

At work I am: □ Constantly moving. □ Somewhat active. □ Not active

How would you rate your current stress level? (Check one)

□ Low □ Moderate □ High □ Very high

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What are the main sources(s) of stress in your life? (Check all that apply)

□ Work □ Family □ Finances □ Relationships □ Health

□ Other:_____

How do you cope with stress? (Check all that apply)

□ Relaxation □ Meditation □ Exercise □ Hobbies □ Socializing □ Eating

□ Drinking □ Smoking □ Other: _____

How would you rate your current sleep quality? (Check one)

□ Good □ Fair □ Poor □ Very poor

How many hours of sleep do you get on average per night? _____

How many times do you wake up?_____ For how long?_____

Do you have any difficulty falling asleep or staying asleep? (Check one) □ Yes □ No

If yes, please explain:_____

Have you been diagnosed with Obstructive Sleep Apnea (OSA)? □ Yes □ No

If no, please check any of the following you have experienced or been observed to have experienced:

□ Loud snoring □ Excessive daytime fatigue □ Morning headaches

□ Waking w/dry mouth □ Gasping for air while sleeping

□ Observed to stop breathing while sleeping

Consent and Signature

I certify that the information I have provided in this form is true and complete to the best of my knowledge. I understand that this information will be used by the medical staff to determine my eligibility and suitability for the medical weight loss program. I consent to undergo a physical examination, blood tests, and other diagnostic procedures as deemed necessary by the medical staff. I also consent to receive counseling, education, and guidance on nutrition, exercise, behavior modification, and medication use as part of the medical weight loss program. I understand that there are potential risks and benefits associated with any weight loss program, and that the results may vary depending on individual factors. I agree to follow the instructions and recommendations of the medical staff, and to report any adverse effects or concerns promptly. I acknowledge that I have read and understood this form, and that I have had the opportunity to ask questions and receive answers.

Name (print):_____ Date: _____

Signature: _____

Provider Signature:_____ Date: _____