





**Review of Symptoms**

|                             |       |    |   |       |    |
|-----------------------------|-------|----|---|-------|----|
| <b>General</b>              |       |    | <b>Infection</b>                        |       |    |
| Fevers                      | yes   | no | HIV                                     | yes   | no |
| Sweats                      | yes   | no | AIDS contact                            | yes   | no |
| Fatigue                     | yes   | no | TB exposure                             | yes   | no |
| Loss of appetite            | yes   | no | Swollen glands                          | yes   | no |
| Bloody sputum               | yes   | no | Recurring infections                    | yes   | no |
| Persistent cough            | yes   | no | Skin infections                         | yes   | no |
| <b>Skin</b>                 |       |    | <b>Exercise Limitations</b>             |       |    |
| Rash                        | yes   | no | Mild                                    | yes   | no |
| Acne                        | yes   | no | Moderate                                | yes   | no |
| Skin cancer                 | yes   | no | Severe                                  | yes   | no |
| Senses                      | yes   | no | <b>Pain in joints</b>                   |       |    |
| Visual problems             | yes   | no | Back                                    | yes   | no |
| Hearing problems            | yes   | no | Hips                                    | yes   | no |
| Ear ringing                 | yes   | no | Knees                                   | yes   | no |
| <b>Neurological</b>         |       |    | Feet                                    | yes   | no |
| Dizziness                   | yes   | no | <b>Arthritis</b>                        |       |    |
| Migraines                   | yes   | no | Where? _____                            |       |    |
| Frequent headaches          | yes   | no | <b>Gastrointestinal</b>                 |       |    |
| Seizures                    | yes   | no | Heartburn/acid reflux                   | yes   | no |
| Strokes                     | yes   | no | Stomach pains                           | yes   | no |
| Memory loss                 | yes   | no | Stomach ulcers                          | yes   | no |
| Shaking                     | yes   | no | Gastritis                               | yes   | no |
| Numbness                    | yes   | no | H. pylori infection                     | yes   | no |
| Uncoordination              | yes   | no | Rectal bleeding                         | yes   | no |
| <b>Genito-urinary</b>       |       |    | Liver disease                           | yes   | no |
| Blood in urine              | yes   | no | Hepatitis or cirrhosis                  | yes   | no |
| Vaginal infections          | yes   | no | Colitis or enteritis                    | yes   | no |
| Stress urinary incontinence | yes   | no | Frequent diarrhea                       | yes   | no |
| Bladder/kidney infections   | yes   | no | Frequent constipation                   | yes   | no |
| Prostate infections         | yes   | no | Crohn's disease                         | yes   | no |
| <b>Sleep apnea</b>          |       |    | Stomach surgery                         | yes   | no |
| Snoring                     | yes   | no | <b>Physical limitations</b>             |       |    |
| Require C-pap               | yes   | no | Climbing stairs                         | yes   | no |
| Daytime drowsiness          | yes   | no | Unusual fatigue                         | yes   | no |
| Frequent waking at night    | yes   | no | Airline travel                          | yes   | no |
| Choking at night            | yes   | no | Lifting from floor                      | yes   | no |
| # of pillows used           | _____ |    | Use of public seating                   | yes   | no |
| <b>Pulmonary disease</b>    |       |    | Personal care                           | yes   | no |
| Short of breath on exertion | yes   | no | Tying shoelaces                         | yes   | no |
| Hay fever                   | yes   | no | Playing with children                   | yes   | no |
| Emphysema/COPD              | yes   | no | <b>Gynecological (females only)</b>     |       |    |
| Pneumonia                   | yes   | no | Last menstrual period                   | _____ |    |
| Asthma                      | yes   | no | Pregnancies                             | _____ |    |
| Aspiration/choking          | yes   | no | Current contraception                   | _____ |    |
|                             |       |    | Any chance you are currently pregnant   | yes   | no |
|                             |       |    | Intending pregnancy in the next 2 years | yes   | no |

---

**Review of Symptoms (*continued*)**

---

**Cardiovascular**

|                                    |     |    |
|------------------------------------|-----|----|
| Heart attack                       | yes | no |
| Congestive heart failure           | yes | no |
| Thrombophlebitis                   | yes | no |
| Swelling of ankles                 | yes | no |
| Chest pain                         | yes | no |
| Coronary heart disease             | yes | no |
| Varicose veins                     | yes | no |
| Heart murmur                       | yes | no |
| Pulmonary embolism                 | yes | no |
| Stroke                             | yes | no |
| Ever taken Fen-Phen                | yes | no |
| Have you had an<br>echocardiogram? | yes | no |

**Psychological**

|   |     |    |
|---|-----|----|
| Depression                                    | yes | no |
| Feeling down                                  | yes | no |
| Suicidal episodes                             | yes | no |
| Mood swings for days at a<br>time             | yes | no |
| Hospitalized for psychiatric<br>reasons       | yes | no |
| Use alcohol or drugs to<br>cope               | yes | no |
| Hospitalized for substance<br>abuse           | yes | no |
| Eating disorder                               | yes | no |
| Vomiting to lose weight                       | yes | no |
| Fasting to lose weight                        | yes | no |
| Laxatives to lose weight                      | yes | no |
| Life more stable than a<br>year ago           | yes | no |
| History of sexual abuse                       | yes | no |
| Psychiatric medications in<br>past or present | yes | no |
| Overeat in reaction to<br>feelings            | yes | no |





---

### Weight Loss History

---

Age you first became overweight \_\_\_\_\_ Weight comfortably maintained \_\_\_\_\_

Highest adult weight \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

*Please circle all that apply*

**Grew up:**    overweight    normal weight    active in sports    under wt.    average wt.

How long have you had a weight problem \_\_\_\_\_

When did you start gaining the weight \_\_\_\_\_

Was there a specific trigger \_\_\_\_\_ If yes, what? \_\_\_\_\_

Do you get cravings \_\_\_\_\_ When? \_\_\_\_\_ How long do they last? \_\_\_\_\_

What foods do you get cravings for? \_\_\_\_\_

Do you binge on foods? \_\_\_\_\_

How many glasses of water do you drink daily? \_\_\_\_\_

What is your motivation for weight loss now? \_\_\_\_\_

**Non-Supervised Attempts**

|                             |  |
|-----------------------------|--|
| Body For Life/Bill Phillips |  |
| Gloria Marshall             |  |
| Health spa                  |  |
| High protein                |  |
| Hypnosis                    |  |
| Low carbohydrate            |  |
| Low fat                     |  |
| Calorie counting on my own  |  |
| Gym membership              |  |
| Home gym equipment          |  |

|                  |  |
|------------------|--|
| Atkins Diet      |  |
| AYDS             |  |
| Mayo Clinic Diet |  |
| Pritikin         |  |
| Richard Simmons  |  |
| Scarsdale Diet   |  |
| Stillman Diet    |  |
| Sugar Busters    |  |
| Slim Fast        |  |
| South Beach Diet |  |
| Other            |  |

**Supervised Weight Loss Attempts**

|                                   |  |
|-----------------------------------|--|
| Diet Pills From MD                |  |
| Diet Shots From MD                |  |
| Diet Center                       |  |
| Overeaters Anonymous              |  |
| Optifast                          |  |
| Weight Watchers                   |  |
| Health Management Resources (HMR) |  |
| Nutri-System                      |  |
| T.O.P.S.                          |  |
| Jenny Craig                       |  |
| New Direction                     |  |
| National Weight Loss              |  |

|                             |  |
|-----------------------------|--|
| Supervised Calorie Counting |  |
| Acupuncture                 |  |
| Psychological Counseling    |  |
| Weigh Of Life               |  |
| Weight Loss Center          |  |
| Exercise Counseling         |  |
| Medifast                    |  |
| Metrical                    |  |
| Nutritional counseling      |  |
| Personal Trainer            |  |
| Other                       |  |
|                             |  |
|                             |  |

**Weight Loss Medications**

|                 |  |
|-----------------|--|
| Acutrim         |  |
| Adipex-P        |  |
| Amphetamines    |  |
| Anorex          |  |
| Benzphetamine   |  |
| Dexatrim        |  |
| Didrex          |  |
| Fastin          |  |
| Fenfluramine    |  |
| Herbal Remedies |  |
| Ionamin         |  |
| Mazanor         |  |
| Meridia         |  |
| Metabolife      |  |

|             |  |
|-------------|--|
| Obalan      |  |
| Orlistat    |  |
| Phendiet    |  |
| Phentermine |  |
| Phentrol    |  |
| Plegine     |  |
| Pondimin    |  |
| Redux       |  |
| Sanorex     |  |
| Tepanol     |  |
| Tenuate     |  |
| Wehless     |  |
| Xenical     |  |
| Other       |  |

**Previous Weight Loss Surgery**

|                               |  |
|-------------------------------|--|
| Gastric bypass (RNY or other) |  |
| Stomach stapling              |  |
| Vertical banded gastroplasty  |  |

|              |  |
|--------------|--|
| Gastric band |  |
| Other        |  |
|              |  |

*Please check all that apply.*

### Nutrition History

|                                   |     |    |  |
|-----------------------------------|-----|----|--|
| How many meals do you eat daily   |     |    |  |
| Do you snack between meals        | yes | no |  |
| Do you drink soda                 | yes | no |  |
| Diet                              | yes | no |  |
| Regular                           | yes | no |  |
| How many sodas do you drink daily |     |    |  |

#### Food Preferences

|                  |     |    |                   |     |    |
|------------------|-----|----|-------------------|-----|----|
| Candy            | yes | no | Fast food         | yes | no |
| Cookies          | yes | no | Seafood           | yes | no |
| Fried food       | yes | no | Cakes or pies     | yes | no |
| Pizza            | yes | no | Vegetables        | yes | no |
| Chocolate        | yes | no | Steak or red meat | yes | no |
| Chips and snacks | yes | no | Dairy products    | yes | No |

**Food allergies** \_\_\_\_\_

#### Last 24 hour Intake

*Please record the typical types of foods and the amounts you eat on a regular basis.*

Before breakfast

Breakfast

Morning break

Lunch

Afternoon snack

Dinner

After dinner

Before bed

Other

Fast Food

Restaurants

