UAB MEDICINE
WEIGHT LOSS MEDICINE
Knowledge that will change your world

NEW PATIENT INTAKE FORM

Date: _____

Patient Name: _____

MRN: _____

Please answer the following questionnaire as completely as possible.

1. Who is your primary care physician or family doctor?_____
2. How did you find out about the UAB Weight Loss Medicine clinic?
   - ☐ Advertisement – Select one: ☐ Billboard ☐ Flyer ☐ Health Fair ☐ Newspaper ☐ Other
   - ☐ Friend/Family/Co-worker
   - ☐ Internet
   - ☐ Physician
   - ☐ Other
3. What is the most you have weighed as an adult?_____ Age at this weight?_____
4. What is the least you have weighed as an adult?_____ Age at this weight?_____
5. What would you like to weigh?_____ Age at your goal weight?_____
6. How has your weight changed during your life? (Check all that apply)
   - ☐ Gradual increase with a small amount each year
   - ☐ One or more rapid increase(s) in weight
   - ☐ Up and down
7. What has caused you to gain weight in the past? (Mark all that apply)
   - ☐ Death/Illness of Family/Friend, Describe:_____
   - ☐ Illness, Describe:_____
   - ☐ Injury, Describe:_____
   - ☐ Quitting Smoking, Describe:_____
   - ☐ Menopause, Describe:_____
   - ☐ Medications, Describe:_____
   - ☐ Stress, Describe:_____
   - ☐ Other, Describe:_____
8. What are you hoping the UAB Weight Loss Medicine clinic can do for you? (Mark all that apply)
   - ☐ Improve health/Feel better
   - ☐ Increase energy/Allow me to do more daily activities
   - ☐ Lose weight
   - ☐ Prevent medical problems
   - ☐ Reverse medical problems/Allow me to stop medications
   - ☐ Other, Describe:_____
9. Have you ever had weight loss surgery? ☐ Y ☐ N

   If YES, Type of Surgery:_____ Date:_____ Weight lost:_____
10. Are you interested in weight loss surgery? ☐ Y ☐ N

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11. Please indicate on list below which of following diet, diet aids, or programs you have tried in the past. For those you have tried, please enter the date started, date stopped, amount of weight loss, reason for stopping the diet, diet aid, or program, and reason for weight regain after stopping.

Name of diet or program	Check if Tried	Start Date	Stop Date	Amount of Weight Lost	Reason for Stopping	Reason Weight Regained After Stopping
On your own	☐					
Atkins or low carbohydrate	☐					
UAB EatRight	☐					
Jenny Craig	☐					
Nutrisystem	☐					
Weight Watchers	☐					
Slimfast	☐					
Optifast	☐					
Other liquid diet	☐					
Other (please specify) _____	☐					

Name of Diet Supplement/Medication	Check if Tried	Start Date	Stop Date	Amount of Weight Lost	Reason for Stopping	Reason Weight Regained After Stopping
Adipex®, Fastin® (Phentermine)	☐					
Alli®, Xenical® (Orlistat)	☐					
Belviq® (Locaserin)	☐					
Dexatrim®	☐					
Herbal weight loss products	☐					
Meredia® (Sibutramine)	☐					
Phen-fen	☐					
Qsymia®	☐					
Redux®	☐					
Other (please specify) _____	☐					

12. How many children under age 18 live with you?_____ Select: ☐ Child(ren) ☐ Grandchild(ren) ☐ Other

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13. Please check if any family members are (or were) overweight or obese:
(Mark all that apply)
☐ Spouse ☐ Son ☐ Daughter ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandparent
☐ Other
14. Will your family support you in your weight loss? ☐ Y ☐ N ☐ Maybe
15. Please indicate if you have a history of any of the following:

Eating disorder	☐ Yes	☐ Not Sure
Anorexia Nervosa	☐ Yes	☐ Not Sure
Binge eating	☐ Yes	☐ Not Sure
Making yourself throw up/Bulimia	☐ Yes	☐ Not Sure
Eating so much at one time that you have to throw up	☐ Yes	☐ Not Sure

Please answer the following Sleep/Restfulness questions:

16. On average over the past month, how many hours of sleep did you get per night?_____
17. Do you feel rested when you wake up? ☐ Y ☐ N
18. Do you snore? ☐ Y ☐ N
19. Have you ever been told to wear CPAP or BiPAP for sleep apnea? ☐ N ☐ Y – I use it _____ nights per week
20. How well have slept over the past month? ☐ Very Good ☐ Fairly Good ☐ Fairly Bad ☐ Very Bad
21. Circle the choice for how likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. Use the following scale for each situation:
0=Would never doze, 1=Slight chance of dozing, 2=Moderate chance of dozing, 3=High chance of dozing

	Chance of Dozing			
Situation	**Would Never Doze**	**Slight Chance**	**Moderate Chance**	**High Chance**
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting in a public place (theatre or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Passenger in a car for one hour or more	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch (without alcohol)	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
				TOTAL: _____

Additional information related to exercise

22. On a typical day, which describes you?
☐ Mostly sitting ☐ Mostly walking ☐ Mostly heavy labor ☐ Unsure
☐ Other:_____

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23. Please check Yes or No for the following:

Do you enjoy exercise?	☐ Yes	☐ No
Do you have a gym membership?	☐ Yes	☐ No
Do you have exercise equipment at home?	☐ Yes	☐ No
Do you exercise regularly?	☐ Yes	☐ No
Do you have any negative feelings about exercise or had any bad experiences with exercise?	☐ Yes	☐ No
Do you have any family members or friends who are willing to encourage you to exercise or possibly exercise with you?	☐ Yes	☐ No

24. How much exercise have you done in the PAST WEEK?

Type of exercise:_____

Length of exercise:_____minutes _____times per week

25. How long have you been exercising regularly (at least 150 minutes per week; such as 5 days a week for at least 30 minutes per session)? _____ months

26. What type of exercise are you currently involved in? (Mark all that apply)

☐ Aerobics classes ☐ Biking, Outdoor ☐ Biking, Stationary ☐ Crossfit/Boot Camp ☐ Elliptical Machine
☐ Exercise videos ☐ Hiking ☐ Pilates ☐ Running ☐ Stretching ☐ Swimming ☐ Walking
☐ Water/Pool Exercise ☐ Weight training ☐ Yoga ☐ Zumba ☐ None
☐ Other:_____

27. What type of exercise do you prefer or would enjoy the most? (Mark all that apply)

☐ Aerobics classes ☐ Biking, Outdoor ☐ Biking, Stationary ☐ Crossfit/Boot Camp ☐ Elliptical Machine
☐ Exercise videos ☐ Hiking ☐ Pilates ☐ Running ☐ Stretching ☐ Swimming ☐ Walking
☐ Water/Pool Exercise ☐ Weight training ☐ Yoga ☐ Zumba ☐ None
☐ Other:_____

28. Were you an athlete in school? ☐ Yes, in high school ☐ Yes, in college ☐ No

29. How confident are you that you could increase the amount of exercise you do? (Check One)

☐ Very confident ☐ Moderately confident ☐ Only a little confident ☐ Not at all confident

30. What are the major benefits of exercise for you? (Mark all that apply)

☐ Increased energy ☐ Improved health ☐ Improved arthritis ☐ Improved mobility
☐ Other:_____

31. What are your major barriers to increasing the amount of exercise you do? (Mark all that apply)

☐ Lack of motivation ☐ Lack of time ☐ Lack of equipment ☐ Lack of access to exercise facilities
☐ Injuries ☐ Health problems ☐ Other:_____

32. How much time are you willing to commit to exercise? _____ minutes/day _____days/week

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Additional information related to diet

33. How confident are you that you can follow a weight loss diet? (Check One)

☐ Very confident ☐ Moderately confident ☐ Only a little confident ☐ Not at all confident

34. What are your major barriers to following a weight loss diet? (Mark all that apply)

☐ Access to healthy foods ☐ Access to cooking appliances (Stove, Microwave, Grill)

☐ Access to refrigerator and/or freezer ☐ Cost ☐ Family/household diet ☐ Food intolerances/dislikes

☐ Healthy food doesn't taste good ☐ Hunger ☐ Lack of family/peer support

☐ Lack of knowledge of food to eat/buy ☐ Religion ☐ Time to plan/prepare healthy diet ☐ Work atmosphere

☐ Other:_____

35. How many times a day do you eat?_____

36. At what times of day do you eat?

☐ Morning ☐ Mid-morning ☐ Noon ☐ Afternoon ☐ Evening ☐ Late night/bedtime ☐ Middle of the night

37. How many people live in your home?_____ Are meals eaten together? ☐ Y ☐ N

38. Who does the grocery shopping? ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

39. Who cooks/prepares the meals? ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

40. Have you done or experienced any of the following in the past 6 months?

	Yes	Details/Comments
Eating when stressed, emotional or bored	☐	
Binge Eating	☐	
Grazing or Frequent Snacking	☐	
Eating in the middle of the night	☐	
Skipping meals	☐	
Eat out at restaurants or ordering take out	☐	
Eating in front of the TV	☐	
Eating at desk/computer/while working	☐	
Eat more than one helping/large portion sizes	☐	
Eating too fast	☐	
Do NOT feel satisfied or full after a meal	☐	

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41. Which of the following do you consume more than once a week?

	Yes	Number Per Day (Average)
Regular soda	☐	
Juice	☐	
Sweet tea	☐	
Alcoholic drinks	☐	
Fried foods	☐	

42. Please indicate the number of servings of each of the below that you typically consume during an average day:

_____ Servings of fruit per day

_____ Servings of vegetables per day

_____ Servings of whole grains per day

_____ Servings of low fat dairy per day

_____ Servings of lean protein per day

43. Do you have any food intolerances or food allergies or are there particular foods you dislike?

☐ No

☐ Yes – Please list:_____

44. Do you have any food cravings?

☐ No

☐ Yes – Please list:_____

PAST MEDICAL HISTORY

Check if you have any of the following now or in the past:

☐ Diabetes, Age at diagnosis _____
☐ Damage to Kidneys from Diabetes
☐ Damage to Eyes from Diabetes
☐ Damage to Nerves from Diabetes
☐ Obstructive Sleep Apnea
☐ High blood pressure
☐ High cholesterol
☐ Thyroid Disease
☐ Arthritis
☐ Cancer, (Type) _____
☐ Heart Attack(s)
☐ Heart murmur/Valve problems
☐ Heart Failure
☐ Organ Transplant, (Type) _____
☐ Other medical conditions (please list):

☐ Polycystic Ovary Disease
☐ Kidney disease
☐ Kidney stones
☐ Dialysis
☐ Pancreatitis
☐ Asthma
☐ Pulmonary embolism
☐ Emphysema, COPD
☐ Reflux/Heartburn
☐ Crohn's disease
☐ Gallstones
☐ Epilepsy (seizures)
☐ Colitis
☐ Stroke

☐ Depression
☐ Anxiety
☐ Cataracts
☐ Glaucoma
☐ Other Eye Disease
☐ Peripheral artery disease
☐ Clotting Disorder
☐ Rheumatoid Arthritis
☐ Lupus
☐ Gout
☐ Other Rheumatologic Disease
☐ Liver disease
☐ Hepatitis
☐ HIV/AID

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