



## Medical Weight Management Health History Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Past Medical History		Diet History				
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Vitamin Deficiency	First ever diet:				
CPAP <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Barrett's Esophagus	Previous Diets (circle all that apply)				
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hypogonadism	Weight Watchers Jenny Craig Logenics Scarsdale				
Medication History		Nutrisystem SlimFast HcG Cabbage Soup Whole30				
<input type="checkbox"/> Testosterone Therapy	<input type="checkbox"/> Hormone Therapy	Keto Atkins South Beach Other:				
Previous Proton Pump Inhibitors Used (circle all that apply)		Previous Medication for Weight Loss (circle all that apply)				
Prevacid Prilosec Protonix Nexium Other		Mounjaro Phentermine Contrave Qsymia Ally				
Length of Therapy:		Ozempic Fenfluramine/Phentermine Other				
Previous Bisphosphonates Used (circle all that apply)		Social History				
Reclast Boniva Fosamax Actonel		Caffeine Use: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Black <input type="checkbox"/> Cream <input type="checkbox"/> Sugar				
Zometa Atelvia Other		Daily Water Intake (ounces/day):				
Length of Therapy:		Exercise Frequency (times/week):      Duration (minutes):				
Past Weight History		Past Surgical History				
High school years		<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Roux-en-Y Gastric Bypass			
20's		Starting weight:	Complications:			
30's		Lowest weight:	<input type="checkbox"/> Endoscopic Sleeve Gastrectomy			
40's		Bariatric Vitamins: <input type="checkbox"/> Yes <input type="checkbox"/> No	Complications:			
50's		<input type="checkbox"/> Lap Band	<input type="checkbox"/> EGD			
60's		Last Fill:	<input type="checkbox"/> Tubal Ligation			
Maximum weight?		Complications:	<input type="checkbox"/> Vasectomy			
Family Obesity History						
Relationship	Age	Living Y/N	Overweight	Obese	Addiction History	Major Medical Problems/Cause of Death
Father						
Mother						
Siblings						
Children						
Pregnancy History						
Pregnancy	Age	Total weight gained	Lost all the weight	Lost some weight	Lost no weight	Total weight lost after pregnancy
First						
Second						
Third						

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_