EMPOWER
WEIGHT LOSS ASSOCIATES
MEDICAL WEIGHT LOSS SOLUTION

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1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Emergency Contact and phone # _____

Your Profession _____

2. **Are you currently under the care of a family physician or any other health professional? If yes, please indicate:**

	Health professional's name	Health professional's contact	Condition
1			
2			

3. **Are you allergic to any medications or foods?**

_____

_____

_____

_____

4. **Please list any prescribed medications you take:**

	Name	Dosage
1		
2		

5. Please list all non-prescription medications you take:

	Name	Dosage
1		
2		

6. Have you been diagnosed with any of the following conditions?

- ☐ Diabetes
- ☐ Cancer
- ☐ Irritable bowel
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Heart Attack
- ☐ Gall Stones/Gall Bladder issues
- ☐ Liver Disease
- ☐ High Cholesterol
- ☐ PCOS
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Bleeding disorder
- ☐ Ulcerative colitis
- ☐ HIV / AIDS
- ☐ Kidney disease
- ☐ Angina
- ☐ Sleep Apnea
- ☐ Reflux/GERD
- ☐ Celiac Disease
- ☐ Infertility
- ☐ None
- ☐ Heart condition
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Osteoporosis
- ☐ Cardiovascular disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Gout
- ☐ Pancreatitis
- ☐ Other(s)

If "other(s)", please specify

7. List any past surgeries:

8. What medical tests or investigations have you had recently? (Include reason for test and results)

9. General: Do you have any of the following symptoms?

- ☐ Fatigue
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain/Loss
- ☐ Trouble Sleeping
- ☐ Snoring
- ☐ Apneic times when asleep

10. On a scale of 1 to 10 indicate where your energy levels are currently:

Energy levels:
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

11. Skin health: Do you have any of the following symptoms or conditions?

- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Dermatitis
- ☐ Hives
- ☐ Itchy sking or body
- ☐ Acne
- ☐ Rash
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

12. Head: Do you have any of the following symptoms?

- ☐ Headache
- ☐ Head Injury
- ☐ Aneurysms
- ☐ Headaches/Migraines
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

13. Ear health. Do you have any of the following symptoms?

- ☐ Recurrent ear infections
- ☐ Tinnitus (ringing ears)
- ☐ Hearing problems
- ☐ Ear Drainage
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

14. Eye health. Do you have any of the following symptoms?

- ☐ Blurry Vision
- ☐ Glasses/Contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Flashing Lights
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

15. Nose health: Do you have any of the following symptoms?

- ☐ Hay fever (allergic rhinitis) (seasonal or all year round?)
- ☐ Frequent nose bleeds
- ☐ Nasal polyps
- ☐ Discharge
- ☐ Sinus Pain
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

16. Throat Health: Do you have any of the following symptoms?

- ☐ Dry Mouth
- ☐ Bleeding Gums
- ☐ Dentures
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Ulcers
- ☐ Thrush
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

17. Neck Health: Do you have any of the following symptoms?

- ☐ Lumps
- ☐ Pain
- ☐ Stiffness
- ☐ Swollen Glands
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

18. Endocrine: Do you have any of the following symptoms?

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Dry and Wrinkled Skin
- ☐ Hair falling out
- ☐ Cold all the time
- ☐ Swelling all over the body
- ☐ Other(s)
- ☐ None

19. Breast Health: Do you have any of the following symptoms?

- ☐ Lumps
- ☐ Discharge
- ☐ Pain/Breast Tenderness
- ☐ Currently breastfeeding
- ☐ Perform self exam
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

20. Respiratory Health: Do you have any of the following symptoms?

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Sputum
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

21. Cardiovascular health: Do you have any of the following symptoms?

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Varicose veins
- ☐ Cold hands and feet
- ☐ Swollen feet or ankles
- ☐ Palpitations on exertion
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

22. Gastrointestinal Health: Do you have any of the following symptoms?

- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Rectal Bleeding
- ☐ Bloating
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

23. Urinary Health: Do you have any of the following symptoms?

- ☐ Urinary incontinece
- ☐ Frequent urination
- ☐ Pain urinating
- ☐ Difficulty urinating
- ☐ Incomplete urination
- ☐ Sudden urgency to urinate
- ☐ Urine leakage when cough
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

24. Genital: Do you have any of the following symptoms?

- ☐ Pain with sex
- ☐ Discharge
- ☐ Erectile Dysfunction
- ☐ Sores
- ☐ Itching
- ☐ Vaginal Dryness
- ☐ Decreased Sex Drive
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

25. Musculoskeletal: Do you have any of the following symptoms?

- ☐ Joint Pain
- ☐ Stiffness
- ☐ Back Pain
- ☐ Trauma
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

26. Neurological: Do you have any of the following symptoms?

- ☐ Seizures
- ☐ Dizziness
- ☐ Fainting
- ☐ Vertigo
- ☐ Numbness/Tingling
- ☐ Weakness
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

27. Psychiatric: Do you have any of the following symptoms?

- ☐ Nervousness
- ☐ Depression
- ☐ Memory Loss
- ☐ Stress
- ☐ Anxiety
- ☐ Mental Confusion/Foggy Brain
- ☐ Mood Changes/Irritability
- ☐ Tension
- ☐ Other(s)
- ☐ None

If "other(s)", please specify

_____

28. Preconception care

Are you and your partner planning on becoming pregnant in the next 6 months?

_____

Have you and your partner been having difficulty becoming pregnant? If applicable, how long have you been trying?

_____

29. Please tick the boxes which indicate ailments that have affected your relatives and specify to which relative (s) the ailments apply :

- ☐ Anxiety
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Thyroid Issues
- ☐ None

30. When did you become overweight?

- ☐ Childhood
- ☐ Teens
- ☐ Adulthood
- ☐ Pregnancy
- ☐ Menopause

Further explanation

31. Have you gained more than 20 pounds within 3 months in your lifetime?

- ○ Yes
- ○ No

Further Explanation if needed

32. How much did you weigh 1 year ago?

33. How much did you weigh 5 years ago?

34. How much did you weight 10 years ago?

35. What are your situational or behavior triggers for weight gain?

- ☐ Stress
- ☐ Marriage
- ☐ Divorce
- ☐ Illness
- ☐ Medication Abuse
- ☐ Travel
- ☐ Injury/Surgery
- ☐ Work
- ☐ Insomnia
- ☐ Quit smoking/alcohol
- ☐ Anger/Depression
- ☐ Reward Seeking
- ☐ Boredom
- ☐ Parties/Social Events
- ☐ none

Further Explanation

36. What are your food triggers associated with cravings or weight gain?

- ☐ Eating Out
- ☐ Fast Food
- ☐ Sugar
- ☐ Carbs
- ☐ Salt
- ☐ none

List any triggers not listed above:

37. What other previous weight loss programs have you tried:

- ☐ Weight Watchers
- ☐ Nutrisystem
- ☐ Medifast
- ☐ Ideal Protein
- ☐ Jenny Craig
- ☐ Atkins
- ☐ South Beach Diet
- ☐ Paleo
- ☐ Ketogenic Diet
- ☐ HCG
- ☐ none

Please list other(s)

_____

38. Which medications below have you tried for weight loss in the past:

- ☐ Phentermine/Adipex _____
- ☐ Meridia _____
- ☐ Xenical/Alli _____
- ☐ Phen-Fen _____
- ☐ Topiramate/Topamax _____
- ☐ Phendimetrazine/Bontril _____
- ☐ Saxenda _____
- ☐ Bupropion/Wellbutrin _____
- ☐ Belviq _____
- ☐ Qsymia _____
- ☐ Contrave _____
- ☐ Diethylpropion/Tenuate _____
- ☐ none _____

Any issues with the medications?

_____

39. How many times a day do you eat and do you skip meals?

_____

_____

_____

_____

40. How many days per week do you workout: Duration of Exercise:

_____

_____

_____

_____

41. What kinds of exercise do you enjoy:

- ☐ Running/Jogging
- ☐ Weights
- ☐ Exercise Classes
- ☐ Boot Camp
- ☐ Swimming
- ☐ Eliptical
- ☐ Other Cardio

List any other exercises

_____

42. What prevents you from working out?

43. Your habits:

	How much?	How often?
Smoking		
Alcohol		
Recreational drugs		
Tea		
Coffee		
Sleeping pills		
Laxatives		

44. How many hours sleep a night do you get on average and do you feel like you are rested in the morning?

45. How did you hear about our clinic?

- ☐ Internet Search
- ☐ Yelp
- ☐ Friend/Family
- ☐ Facebook
- ☐ Instagram
- ☐ Other

Name of Family/Friend-