UnityPoint Weight Loss
6600 Westown Parkway
Suite 220
West Des Moines, Iowa 50266
Phone (515) 241-2250
Fax (515) 241-2265

Please Print Clearly

Patient First Name:_____ Middle Initial_____ Last_____

List Previous name(s): _____

Address: _____City: _____

Phone Numbers: Home:_____ May we leave a message? Yes/No

Cell: _____ May we leave a message? Yes/No

Social Security #_____ Age:_____ Race:_____

Date of birth_____ Male or Female Marital status: M S D W

Email: _____

Employer:_____Occupation:_____

Work Phone #: _____ May we leave a message? Yes/No

Employment status: Full-Time Part-Time Student Disabled Retired

If disabled, please state reason: _____

Name of Spouse/Partner:_____

Spouse/Partner Employer: _____ Phone #:_____

Name of emergency contact (not living at same address): _____

Emergency contact phone#: _____ Relationship to patient:_____

Referring Physician or Primary Care Physician: _____

Physician's Address: _____

Physicians Phone #: _____ Fax #: _____

Insurance Information

Primary: _____ Secondary:_____

Billing Information

Responsible Party (If same as patient skip to bottom of page) _____

Relationship to patient: _____ Social Security# _____

Date of birth: _____ Phone #: _____

Signature_____ **Date:**_____

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Bariatric Questionnaire

Pharmacy Name:_____

Pharmacy Address: _____

Pharmacy Phone #:_____ Fax#: _____

How did you hear about us? (internet, Primary Care Physician, Friend/family, TV commercial, etc.) _____

_____

Weight History

Age at onset of obesity: _____ Were you obese before puberty? Yes / No

What is your lifetime maximum weight? _____ When? _____

What types of diets have you tried in the past? (please circle)

Atkins, Weight Watchers, Low Carb, Low Fat, NutriSystem, Slim Fast, South Beach, Calorie Counting)

others:_____

What are your barriers to weight loss? (busy schedule, lack of motivation, cost of healthy eating)_____

_____

Do you feel that you are overweight because: (check all that apply)

_____ I eat normal amounts of food but have an abnormal metabolism
_____ I eat larger amounts of normal foods
_____ I eat larger than normal amounts of normal foods as well as sweets/snacks
_____ I am an emotional eater.
_____ I am a nighttime eater.
_____ I do not exercise enough.
_____ I need more information on lifestyle adjustments to manage my weight.
_____ I have physical limitations that have caused weight gain.

Other:_____

Who do you live with/spend most of your time with?_____

Does he/she support your weight loss goals?_____

Who else supports your weight loss goals?_____

What is your occupation?_____

How many hours a day are you sitting?_____ Standing?_____ Sleeping?_____ Watching TV?_____ Sleeping?____

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Nutrition

Who does most of the grocery shopping in your home?_____

How often are you able to afford healthy foods? (always, occasionally, never)_____

Who does the meal planning at home?_____

Who does most of the cooking in your home?_____ How often do you eat out?_____

Do you snack in between meals?_____ What do you snack on?_____

Do you snack before bed?_____ What do you snack on?_____

Do you get up during the night to eat?_____

How many sodas do you drink per day?_____ . Is it regular or diet soda?

Other caffeinated beverages?_____ How much water to do you drink daily?_____

Do you eat breakfast? YES / NO Do you skip any meals? YES / NO If so, which ones: Breakfast / Lunch / Dinner

Do you feel like you achieve a sense of fullness?_____ Do you keep a food journal?_____

24 hour diet recall: Breakfast yesterday?_____

Lunch yesterday?_____

Dinner yesterday?_____

Snacks?_____

Do you have food intolerances?_____ Do you have food allergies?_____

Emotions

How would you describe your mood most of the time?_____ Are you an emotional eater?_____

Describe current stressors in your life_____

Have you ever seen a counselor?_____

Do you have a diagnosis of depression?_____ Do you feel like it is controlled?_____

Do you eat when you are bored or stressed?_____

Have you ever tried laxatives, diuretics, vomiting, binging or purging for weight loss?_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest/pleasure in doing things
   Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
2. Feeling down, depressed and hopeless
   Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)

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Social History

Do you have any history of tobacco use? Yes / No

Do you use smokeless products? (please circle) Chewing Vapor E-cigarettes

Do you currently smoke? Yes / No Packs per day: _____ # of years_____ Quit date:_____

Do you drink alcohol? Yes / No Drinks per week:_____ Drinks per month_____# of years____Quit date:_____

Describe your frequency: Occasional-Use / Moderate Consumption / Excessive Consumption / Binge

Do you use recreational or illegal drugs? (Examples: marijuana, methamphetamines, cocaine or excess of inappropriate use of pain medication) Yes / No Specific type:_____# of years____Quit date:_____

Exercise:

Do you exercise? Yes / No How often?_____ For how long?_____

What type of exercise do you do?_____

Are you a member/have access to a gym?_____ What type of exercise do you enjoy?)_____

What time of day works best for you to exercise?_____

What exercise equipment do you have at your home? (Examples: bands, weights, treadmill, videos) _____

How far can you walk? _____

Please **circle** the following activities that you **CAN** do **without** needing to stop and rest?

If you stop to rest, what are the **main reasons you stop**? (circle all that apply)

Short of breath / Fatigue / Chest Pain / Back Pain / Hip Discomfort / Knee Discomfort / Ankle Discomfort

Do you use an assistive device to aid in mobility (walker, cane, wheelchair, scooter, etc.)? Yes / No

If yes, describe_____

Energy

Do you feel like you have enough daily energy?_____ Do you feel rested upon arising?_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading ____ Watching TV ____ Sitting, inactive in a public place ____

As a passenger in a car for an hour without a break ____ Sitting and talking to someone ____

Lying down to rest in the afternoon when circumstances permit ____

Sitting quietly after lunch without alcohol ____ In a car, stopped for a few minutes in traffic ____

Do you wear a CPAP at night?_____

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Surgical History

List any **previous operations** you have had:

Operation	Date	Problems

List any hospitalizations you have had for an illness or accident **NOT** requiring surgery:

1._____
2. _____
3. _____
4. _____

Allergies

List all medications/medical products to which you have an allergic or bad reaction.

Medication/ medical product	Type of reaction

Medications

List all medications you take. Include **prescription medications**, **over the counter** medication and **vitamins/supplements**. (Also, include any inhalers, breathing devices/machines such as **CPAP/BiPAP** or injections such as birth control or vitamins).

Medication	Dosage/amount	Number of times taken daily

Yes / No Have you taken steroids such as prednisone or cortisone in the last 6 months?
What were the steroids taken for? _____

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Medical History

Please place an **"X"** in the past or present for the following medical problems. Explain in the space next to the problem.

Past	Present	Medical Problem
___	_____	Easy bruising or easy bleeding, blood transfusion, anemia or low blood counts
___	_____	Blood clot or embolus
___	_____	Thyroid problems. What was your last TSH level?_____
___	_____	Seizure or epilepsy
___	_____	Migraine headache
___	_____	Arthritis or degenerative joint disease (Hips, Knees, Ankles, Feet)
___	_____	Rheumatoid Arthritis
___	_____	Fibromyalgia
___	_____	Low back pain
___	_____	Tuberculosis
___	_____	Asthma diagnosis, COPD, or other lung or breathing problems
		Have you seen a lung doctor? Yes / No
___	_____	Sleep apnea Do you use CPAP/BiPAP? Yes / No
		Do you snore? Yes / No Have you had a sleep test? Yes / No
___	_____	Peripheral edema (swelling of the legs, ankles)
___	_____	Rheumatic fever
___	_____	Congestive heart failure
___	_____	Irregular heart rhythm or palpitations
___	_____	Heart attack or angina (chest pain, pressure or tightness)
		Have you ever seen a heart doctor? Yes / No Did you have heart testing done? Yes / No
		What was the name of heart doctor:_____ When were you seen: _____
___	_____	High cholesterol (diagnosed or high lab result?)
___	_____	High triglycerides (diagnosed or high lab result?)
___	_____	Hypertension (high blood pressure)
___	_____	Stroke
___	_____	Diabetes (Type I, Type II) When was it diagnosed?_____
		What was our last HbA1c?_____ Do you use insulin?_____
		Do you have problems with eyes, kidneys or neuropathy?_____
___	_____	Gastroesophageal reflux disease or frequent heart burn
		Do you take any reflux medications? Yes / No How often? _____
		Do you have difficulty swallowing pills, bread, or other food? Yes / No What foods?_____
		Any problems swallowing liquids? Yes / No
		Have you ever had an endoscopy or EGD to look at your stomach? Yes / No
___	_____	Irritable bowel syndrome
___	_____	Crohns, or Ulcerative colitis
___	_____	Liver problems or hepatitis
___	_____	Gallstones
___	_____	Gout
___	_____	Hernia (umbilical, groin, incisional)
___	_____	Kidney or bladder problems, or kidney stones
___	_____	Stress incontinence (leak urine with coughing or laughing)
___	_____	Polycystic Ovarian Syndrome or problems with fertility
___	_____	Cancer Type:_____
___	_____	Anxiety
___	_____	Depression treated with medications or counseling
		Are you currently seeing a mental health provider? Yes / No Clinic Name: _____
___	_____	Physical or sexual abuse in childhood (please circle)
___	_____	Physical or sexual abuse in adulthood (please circle)
___	_____	Alcoholism
___	_____	Substance abuse
___	_____	Psychiatric illness (such as bipolar, schizophrenia, etc)

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Have you had a Colonoscopy? No / Yes Date:_____
Have you had a Mammogram? No / Yes Date:_____

Family History

Do any of your blood relatives have the following problems? Explain which relative and type of problem in the space provided. Specify maternal vs. paternal.

Alcoholism_____
Cancer_____
Heart Disease_____
Kidney Disease_____
Liver Disease_____
Diabetes_____
Obesity_____
Lung Disease_____
Stroke_____
Lung Disease_____
Rheumatoid Arthritis_____
Mental Illness_____
Other Illness _____

General symptoms

Do you have any of the following symptoms?	Yes	No
Acid reflux		
Arthritis or severe joint pain		
Back pain		
Black or tarry stools		
Blackouts or periods of dizziness		
Blood in your sputum		
Burning with urination or frequent urination		
Chest pain		
Chronic cough or sputum (phlegm) production		
Diarrhea		
Difficulty swallowing		
Excessive bleeding following minor cuts or dental surgery		
Fever		
Frequent or new constipation		
Irritable Bowel Syndrome		
Nausea		
Palpitations or irregular heart beat		
Pregnancy		
Shortness of breath when walking up one flight of stairs		
Swelling in the ankles		
Ulcers		
Temporary weakness or numbness		
Temporary loss or blurring of vision		
Weight gain or loss greater than 10 pounds in the past 3 months		