WVUMedicine

Medical Weight Management Intake Form

PHONE: **304-598-4890** FAX: **304-598-6249** **PO Box 9238 Morgantown, WV 26506-9238**

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

(Preferred Name) _____ Current Age: _____ DOB: _____/_____/_____

Describe weight history:

0-12 years old	☐ **Underweight**	☐ **Average Weight**	☐ **Overweight**	☐ **Very overweight or obese**
13-18 years old	☐ **Underweight**	☐ **Average Weight**	☐ **Overweight**	☐ **Very overweight or obese**
19-35 years old	☐ **Underweight**	☐ **Average Weight**	☐ **Overweight**	☐ **Very overweight or obese**
35-50+ years old	☐ **Underweight**	☐ **Average Weight**	☐ **Overweight**	☐ **Very overweight or obese**

Highest (non-pregnant) weight: _____ lbs. When: _____ Weight at age 18: _____

If you had bariatric surgery, lowest weight achieved: _____ lbs. Lowest was after _____ months.

Current weight: _____ Current height: _____

Describe weight history. (Has gain been gradual or were there life events that affected weight, such as pregnancy, quitting smoking, emotional factors, personal issues, or job changes?)

_____

_____

Any current barriers to weight-loss? _____

What is your motivation for wanting to lose weight? _____

What are you hoping to get out of this program? _____

WEIGHT-LOSS ATTEMPTS

Previous weight-loss attempts *(Weight Watchers, Jenny Craig, Nutrisystem, Atkins, self-monitoring plan, work with dietitian, bariatric surgery, etc.)*

Name of attempt: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

Name of attempt: _____ Length of time: _____ Lbs. lost: _____

Comments: _____

Weight-loss medications used *(Meridia, Orlistat, Qsymia, Belviq, Phentermine, HCG, Dexatrim, Metabolife)*

Name of medicine: _____ Length of time: _____ Lbs. lost: _____

_____

WVUMedicine

Medical Weight Management Intake Form

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

EATING HABITS

On a special diet currently or have any dietary restrictions (describe)? _____ Length of time: _____

Who does the grocery shopping: ☐ **Self** ☐ **Other**: _____

Who does the meal preparation: ☐ **Self** ☐ **Other**: _____

FOOD SECURITY

In last 12 months, did you worry about food running out before you got money to buy more? ☐ **Yes** ☐ **No**

In last 12 months, did the food run out before you got money to buy more? ☐ **Yes** ☐ **No**

On a limited food budget/rely on food stamps, food pantry for food? ☐ **Yes** ☐ **No** If yes, explain: _____

Mark if any of the following common issues often apply to you. Keep in mind that each person has different struggles.

☐ **Irregular eating timing (variable eating times, lack of routine, skipping meals)**

☐ **Snacking between meals.** If yes, explain: _____

☐ **Majority of food is snacks rather than meals**

☐ **Eating quickly (less than 10 minutes)**

☐ **Portion sizes larger than needed**

☐ **Eating until uncomfortably full**

☐ **Eating mindlessly (while doing something else, like watching TV, or in car).** If yes, when? _____

☐ **Eating "out"** (fast food, restaurant, carry-out, etc.) If yes, is it fast food, sit-down restaurant, take-out, cafeteria, or other:

Times per week: _____ _____

☐ **Emotional eating.** If yes, how often, and triggers: _____

☐ **Addictive tendencies toward any foods.** If yes, explain: _____

☐ **Hunger**

☐ **Have "problem" foods (that you tend to crave or overeat) or foods that trigger overeating like sweets or salty foods).**

If yes, examples: _____

☐ **Eat processed convenience foods (ex., ready-made, boxes meals).** If yes, examples: _____

☐ **Eating less than 5 servings total fruits and vegetables/day.** Number fruit serving and examples: _____

Number of vegetable servings and examples: _____

☐ **Eating "sweets" (candy, cookies, etc.)** Examples and frequency: _____

☐ **Poor support system (unsupportive friends/family)** If yes, examples: _____

☐ **Often tempted to eat by foods seen or smelled, esp. at home or work.** If yes, examples: _____

☐ **Eat more than 25% of food after evening meal.**

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

EATING HABITS - CONTINUED

Please indicate your servings of beverages in an average day:

Juice			☐ None	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6+
Soda	☐ Regular	☐ Diet	☐ None	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6+
Tea	☐ Sweet	☐ Un-sweet	☐ None	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6+
Coffee	☐ Cream	☐ Sugar	☐ None	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6+
Water			☐ None	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6+

AUDIT C

In the past year:	0	1	2	3	4
How often did you have a drink containing alcohol?	☐ Never	☐ 1 day per month or less	☐ 2-4 days per month	☐ 2-3 days per week	☐ 4+ days per week
On a typical day when drinking alcohol, how many drinks did you have?	☐ 1-2	☐ 3-4	☐ 5-6	☐ 7-9	☐ 10+
How often have you had 6+ drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily
Total Score:					

Common alcoholic beverages consumed: _____

Describe food or beverage consumed in past 24 hours (include amount eaten and method of prep)	**Time**	**Calories** (if known)

PHYSICAL ACTIVITY

Physical activity in a typical day NOT from formal exercise:

☐ **Sedentary (sitting most of day)** ☐ **Active (standing most of day)** ☐ **Very active (walking most of day)**

Physical activity from formal exercise:

Days/week exercise outside normal daily activity: _____ days (A)

Minutes each day exercise is performed: _____ minutes (B)

Days (A) x minutes (B) = _____ minutes per week (Physical Activity Vital Sign)

Describe: _____

How many days per week muscle strengthening exercises? _____ days

Describe: _____

Describe any activity limitations: _____

Able to stand or walk by one's self for greater than 15 minutes without pain/need to sit? ☐ **Yes** ☐ **No**

Time spent on TV in a day (hours): _____ Time spent on computer/phone in a day (hours): _____

WVU Medicine

Medical Weight Management Intake Form

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

SLEEP EVALUATION

Average hours of sleep per night: _____

Do you often have insomnia? ☐ Yes ☐ No

Do you wake up tired after a night's sleep (non-restorative sleep)? ☐ Yes ☐ No

PROMIS Sleep: Circle the appropriate choice that describes your sleep in the past 7 days

In the past 7 days	1	2	3	4	5
My sleep was restless	Not at all	A little bit	Somewhat	Quite a bit	Very much
I was satisfied with my sleep	Very much	Quite a bit	Somewhat	A little bit	Not at all
My sleep was refreshing	Very much	Quite a bit	Somewhat	A little bit	Not at all
I had difficulty falling asleep	Not at all	A little bit	Somewhat	Quite a bit	Very much
I had trouble staying asleep	Never	Rarely	Sometimes	Often	Always
I had trouble sleeping	Never	Rarely	Sometimes	Often	Always
I got enough sleep	Always	Often	Sometimes	Rarely	Never
My sleep quality was	Very good	Good	Fair	Poor	Very Poor
Total Score:					

Do you have Sleep Apnea? ☐ Yes ☐ No

If yes, do you wear a CPAP or Bipap machine at night? ☐ Yes ☐ No

Epworth

If you are NOT currently being treated for sleep apnea, please answer the questions below.

1. Do you snore? ☐ Yes ☐ No
2. Has anyone ever told you that you stopped breathing at night? ☐ Yes ☐ No
3. Do you wake up at night gasping for breath or wake up feeling as if you are smothering? ☐ Yes ☐ No

If you are NOT currently being treated for sleep apnea, use the scale below to choose the best number to rate each situation and your chance of dozing off during these situations.

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

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater, meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon, when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
	Total:

WVU Medicine

Medical Weight Management Intake Form

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

SOCIAL HISTORY

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Life Partner

Who lives in the home with you? _____

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you currently use tobacco products? ☐ Current ☐ Past ☐ Present How much and what type: _____

Do you currently use Marijuana products? ☐ Yes ☐ No

Highest level of education: _____

What is your occupation? _____ Do you work night shifts? ☐ Yes ☐ No

FAMILY HISTORY

Please indicate if there is a family history of:

Overweight/Obesity	☐ Child	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other: _____
Diabetes (Type II)	☐ Child	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other: _____
Thyroid Cancer	☐ Child	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other: _____
Stroke	☐ Child	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other: _____
Heart Disease	☐ Child	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Other: _____

Other notable family history, such as cancer: _____

PAST MEDICAL HISTORY

Are you a WVU Medicine patient? ☐ Yes ☐ No
If yes, go to the next page if you prefer we obtain the information below from reviewing your electronic health record with you.

Please list chronic medical conditions: (diabetes mellitus, high blood pressure, cancer, heart or lung disease)

_____

_____

_____

_____

Please list any previous surgeries (include any biopsy or cosmetic surgery)

_____

_____

_____

_____

Please list any prescription medications that you are currently taking: (including over the counter supplies, supplements, vitamins, or herbals)

Name	Dosage instruction	Name	Dosage instruction

WVU Medicine

Medical Weight Management Intake Form

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

REVIEW OF SYSTEMS

Do you have a history of glaucoma?	☐ Yes	☐ No	If yes, detail _____
Have you ever had diabetes (even if remission)?	☐ Yes	☐ No	If yes, detail _____
Do you feel thirsty frequently or urinate often?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of thyroid disease?	☐ Yes	☐ No	If yes, detail _____
Do you get chest pain?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of heart valve problems?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of heart disease, coronary artery	☐ Yes	☐ No	If yes, detail _____
disease, heart attack, coronary artery bypass, angioplasty,	☐ Yes	☐ No	If yes, detail _____
heart stent, arrhythmia?			
Do you have congestive heart failure?	☐ Yes	☐ No	If yes, detail _____
Have you had any testing done on your heart?	☐ Yes	☐ No	If yes, detail _____
Do you have asthma, shortness of breath, or wheezing?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of sleep apnea?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of GERD (acid ref ux)?	☐ Yes	☐ No	If yes, detail _____
Do you frequently get abdominal pain?	☐ Yes	☐ No	If yes, detail _____
Do you get nausea, vomiting, constipation, diarrhea?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of pancreatitis?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of liver problems or high liver enzymes?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of bladder leakage?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of kidney stones?	☐ Yes	☐ No	If yes, detail _____
Do you have problems with sexuality, such as loss of desire or	☐ Yes	☐ No	If yes, detail _____
erectile dysfunction?			
Do you get headaches or ever had migraines?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of a stroke or mini-stroke?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of seizures?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of joint pain or back pain?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of gout?	☐ Yes	☐ No	If yes, detail _____
Were you born by C-section?	☐ Yes	☐ No	If yes, detail _____
Were you solely bottlefed formula as a baby?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of depression?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of anxiety?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of Post Traumatic Stress Disorder	☐ Yes	☐ No	If yes, detail _____
(PTSD)?Do you have any other mental health condition?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of substance abuse or addiction?	☐ Yes	☐ No	If yes, detail _____
Do you have a history of anorexia or bulimia?	☐ Yes	☐ No	If yes, detail _____
Would you rate your stress level as high?	☐ Yes	☐ No	If yes, detail _____
Women only: Do you have irregular periods or PCOS?	☐ Yes	☐ No	If yes, detail _____
Women only: Do you have a history of infertility?	☐ Yes	☐ No	If yes, detail _____
Women only: Are you planning or at risk for pregnancy in next year and not using birth control?	☐ Yes	☐ No	If yes, detail _____
Women only: Did you have pregnancy complications?	☐ Yes	☐ No	If yes, detail _____

WVU Medicine

Medical Weight Management Intake Form

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

BEHAVIORAL HEALTH

SCOFF Screening Tool

1. Do you ever make yourself sick because you feel uncomfortably full? ☐ Yes ☐ No
2. Do you worry you have lost control over how much you eat? ☐ Yes ☐ No
3. Have you recently lost more than fifteen pounds in a three month period? ☐ Yes ☐ No
4. Do you believe yourself to be fat when others say you are too thin? ☐ Yes ☐ No
5. Would you say that food dominates your life? ☐ Yes ☐ No

Total of yes answers: _____

Using the scale below, choose the best number to best describe how often you have been bothered in the **last two weeks**.

Scale: 0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day

Situation	Scale
Feeling nervous, anxious, or on edge	
Not being able to stop or control worrying	
Worrying too much about different things	
Trouble relaxing	
Being so restless that it's hard to sit still	
Becoming easily annoyed or irritable	
Feeling afraid, as if something awful might happen	

GAD-7 Total:

Situation	
Little interest or pleasure in doing things	
Feeling down, depressed, or hopeless	
Trouble falling or staying asleep, or sleeping too much	
Feeling tired or having little energy	
Poor appetite or overeating	
Feeling bad about yourself, that you are a failure, or have let yourself or your family down	
Trouble concentrating, like when reading the paper or watching TV	
Moving or speaking so slowly that others could have noticed. Or so fidgety/ restless that you've been moving more than usual	
Thoughts that you would be better off dead or of hurting yourself	

PHQ-9 Total:

PHONE: 304-598-4890 FAX: 304-598-6249 PO Box 9238 Morgantown, WV 26506-9238

BEHAVIORAL HEALTH - CONTINUED

Binge Eating Disorder (BEDS-7)

During the last three months:

A. Did you have any episodes of excessive overeating (eating significantly more than what most people would eat in a similar time? ☐ **Yes** ☐ **No** If "no," *you do not need to fill out the rest of this page*. **If "yes," continue to B.**

B. Do you feel distressed about your episodes of excessive overeating? ☐ **Yes** ☐ **No**

If "no," *you do not need to fill out the bottom portion of this page.* **If "yes," see below.**

Statement about feelings during episodes (only do if you answered yes to B above.)

How often did you feel you had no control (not able to stop, compelled to eat, go back and forth for more food)?
☐ **Never or rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

How often did you continue eating even though not hungry?
☐ **Never or rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

How often were you embarrassed by how much you ate?
☐ **Never or rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

How often did you feel disgusted with self or guilty after?
☐ **Never or rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

During last 3 months, how often did you make yourself vomit to try to control your weight or shape?
☐ **Never or rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

Would you like a referral to a bariatric psychologist? If you marked "Sometimes," "Often," or "Always" to any of the above, a referral is recommended.

☐ **Yes** ☐ **No**

WVUMedicine

Medical Weight Management Intake Form

PHONE: **304-598-4890** FAX: **304-598-6249** **PO Box 9238 Morgantown, WV 26506-9238**

CHOICES AND GOALS

As described in our orientation video, our program is individualized. If you haven't seen it, please go to **wvumedicine.org/weightmgmt** to hear about your options.

Please indicate choices, if known. May discuss first at appointment.
Food: The program includes several eating pattern options (indicate 1st and 2nd choices.)

_____ Flexible healthy eating pattern
_____ Mediterranean or similar eating pattern
_____ Plant-based or vegetarian—describe: _____

_____ Meal replacements (Involves purchasing a separate meal system; may be good option for those needing to lose weight quickly, such as before surgery

_____ Other (name) _____

Movement: The program includes physical activity. Please indicate your choice(s):

_____ Walking
_____ Human Performance Lab (additional fee; recommend initial and periodic evaluations at minimum)

_____ Physical Therapy (currently in or need)
_____ Gym (name) _____
_____ Other (name) _____

Are there any other types of physical activity you would enjoy and may consider adding?

Behavior: The program includes self-monitoring. How would you like to log your food and behaviors?:
Paper ☐ **App** ☐ If app, please name: _____

What lifestyle change goals would you like to make or maintain (such as in the areas of food, physical activity, sleep or other)?

_____

Your personal goal weight: _____ lbs.

Optional supplemental programs can provide support. Please indicate your interest in these programs below:

☐ Finding Wellness ☐ Diabetes Prevention Program ☐ Commercial program; please name: _____

☐ Referral to bariatric psychologist ☐ Community program; please name: _____

☐ Shared Medical Appointments (SMAs). SMAs include an educational discussion and a medical visit in a group setting. They are highly recommended as the support has been shown to help with weight loss. Participating in SMAs may enable you to be seen more often.

Medical: The program may include prescription weight-loss medications or bariatric surgery if you are a candidate (will be decided by the medical physician and/or bariatric surgeon).

Please indicate if you would consider these options:

Medications: ☐ **Yes** ☐ **No** ☐ **Maybe if needed later** Comments: _____

Bariatric surgery: ☐ **Yes** ☐ **No** ☐ **Maybe if needed later** Comments: _____

SCHEDULE

Recommended Schedule: After your first visit, you will have a 1-2 week follow-up with the registered dietitian. After that, you'll have medical visits approximately once a month, either as individual visits or an SMA (described above). We practice team-based care, so at your visits, you may be seen by a physician, advanced practice provider, dietitian, nurse, or other health professional. Our team communicates regularly, so all team members are aware of your goals and plan.

☐ Prefer visits more frequent than monthly ☐ Prefer visits less frequent than monthly ☐ Decline registered dietitian visit

Please select preferred visit type: ☐ Video ☐ Telephone ☐ In-person ☐ Combination of in-person and virtual

Note: Certain conditions, medications, or participation in our meal replacement plan may require in-person visits, and we may ask you to be seen in-person at least yearly.

Genetic Testing: If you had obesity by the age of 10, you may qualify for free genetic testing. Please indicate your preference:

☐ Test ☐ No test ☐ Prefer to discuss further ☐ Do not qualify