my Medical Makeover®

Weight-loss Patient Information

Name:_____ **DOB:**_____
Current weight:_____ Amount you would like to lose:_____
Your ideal weight:_____ Last time (if ever) you were at that weight:_____
Why would you like to lose weight:_____
Does your weight fluctuate a lot?_____
How long have you been unhappy with current weight?_____
What factors do you think contributed to your weight gain? ☐Stress ☐Lack of exercise ☐Fatigue ☐Hormones
☐ Medical reasons:_____ ☐ Other:_____
How does your current weight affect your lifestyle, physical & mental health?_____
What are your concerns with the process of losing weight?_____
What diets have you tried in the past?_____
How much did you lose?_____ How long did you keep it off?_____
Any problems with previous diets? If yes, explain:_____
Have you tried any diet pills?_____ Type:_____
Were you successful with the pills?_____
Have you ever had weight loss surgery or a Lap band procedure?_____ When?_____

Do you exercise regularly?_____
If yes, what is your normal routine?_____
Do you eat a healthy well-balanced diet?_____ Do you eat vegetables every day?_____
Are you a vegetarian?_____ Are you on a special diet now?_____
Do you have any food allergies or intolerances?_____

How often do you eat any of the following?

	>1 a day	Once daily	2 – 4 a week	Once weekly	rarely
Candy					
Chips					
Chocolates					
Desserts					
Fried foods					
Sodas					

Do you have normal size portions?_____ Do you often go back for "seconds"?_____
Do you have strong food cravings?_____ For what?_____
Are you often very hungry?_____
Do you have increased hunger at certain times of day?_____ When?_____
Are you "full" after normal-sized meals?_____ Do you snack between meals?_____
Do you eat late at night?_____ How often?_____
Do you currently have, or ever had, an eating disorder?_____
Do you suffer from any anxiety, depression, OCD, or any other mood disorders?_____
Do you use food to soothe or comfort you?_____
Do you eat out of boredom?_____ Do you use food as a stress reliever?_____
What is your current stress level (1-10)?_____
What are your most pressing stressors right now?_____

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What did you eat yesterday for:

Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Drinks:	
Is this a typical day for you?	
If not, what does a typical day look like?	
Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Drinks:	
How much **alcohol** do you drink daily?	Weekly?
Do you **smoke**?	How many packs per day?

Medical History:

Do you have or ever had any of the following:	**Yes**	**No**
Polycystic ovarian disorder		
Ovarian cysts		
Menopause		
Low testosterone		
Obstructive sleep apnea		
High blood pressure		
High cholesterol or Triglycerides		
Diabetes		
Insulin resistance		
Blood clots or clotting disorder		
Gallbladder dysfunction or gallstones		
Gallbladder removed		

Please rate your energy levels 1- 10

Upon waking	1	2	3	4	5	6	7	8	9	10
Mid-morning	1	2	3	4	5	6	7	8	9	10
Noon	1	2	3	4	5	6	7	8	9	10
3 p.m.	1	2	3	4	5	6	7	8	9	10
Before bed	1	2	3	4	5	6	7	8	9	10

Do you get enough sleep?
How many hours per night?
Any difficulties sleeping?
Staying asleep?
Waking too early?

Females only:

Are you pregnant or breastfeeding?
If not, do you plan on getting pregnant?
Last menstrual cycle?
Are your cycles regular?

Patient Signature

Today's Date

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