Name: ___________________________________ **Date:** ________________________

Revised 6-1-11

Oregon Medical Weight Loss

Patient Intake Information

Best # to reach you _______________________ May we leave a message here, for you? (Y/N)
Alternate Phone: ________________________ May we leave a message here, for you? (Y/N)
Address:________________________________ Email address ______________________________________
City________________State_____Zip__________ May we send you email information about weight loss (Y/N)
Age _________________D.O.B.____________ Primary Care Provider_________________________________
Occupation______________________________ What is your Preliminary Goal Weight?_________________

How did you hear about us? □ I'm a current patient □ A friend □ Referred by _________________________
On line via: □ Oregon Medical Weight Loss □ SW Family Physicians □ Other________________________

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form in its entirety.

Current Marital Status (circle one): Single Engaged Married Separated Divorced Widowed Domestic Partner
Are you content with your current status? (Y/N) _____ If no, please explain: ______________________________

____

What is your main reason for deciding to lose weight now? ____
List activities you are **not** doing now, but would **like** to do in the future: ________________________________
When did you begin gaining excess weight? (Give reasons if known): _____________________________________

____

What has been your maximum lifetime weight (non-pregnant) and when? ___________________________________
Has your weight changed in the last 2-3 months? ____
Any history of eating disorders, now or in the past? Please explain ______________________________________

____

What are your expectations of us (your medical team)? Be specific: _______________________________________

____

Previous diets you have followed:	Dates	Results of your weight loss:	Any weight regained?:

Which was you best "diet success" and why did it work well for you. ______________________________________

____

How often do you eat out? ______________________ How often do you eat "fast foods"? ___________________________
In your household, who plans meals? ________________ Cooks? ________________ Shops? _____________________
Is your spouse or partner overweight? NO YES If so, approximately how much?_________________________________
Foods you crave? ____
What are your worst food habits? ____
Please describe your snack habits: ____
Do you drink sodas? YES NO How much daily? ______________________ Do you use a sugar substitute? YES NO
Do you drink alcohol? YES NO How much daily/weekly? ____
Do you drink coffee or tea? YES NO How much daily? ____
Do you awaken hungry or eat during the night? YES NO
Do you feel you are an emotional eater? YES NO Please list circumstances that trigger this emotional eating behavior.

____

Have you used appetite suppressants in the past? YES NO If so, which ones? ___________________________
What were the results? ____
If your favorite food is in the refrigerator, do you find it hard to sleep well? YES NO

Name: ________________________________ **Date:** ______________________

Revised 6-1-11

Typical Breakfast	Typical Lunch	Typical Dinner
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Please list any conditions, illnesses, or treatments that might be relevant to your visit today: _______________

____

____

Do you feel you are you in good health at the present time? YES NO If not, why?

Are you under any other doctor's care at the present time? If yes, Who? (and for what)___________________

____

When you are in a stressful situation that is work or family related, do you tend to eat more? Explain_________

____

____

Are you currently undergoing any stress or emotional upset? Explain: ________________________________

____

Are you currently experiencing any suicidal thoughts? ____

Have you seen a mental health provider for services? Please explain:___________________________________

Have you ever been hospitalized for psychiatric, drug, or alcohol addiction? ___________________________

Date:_____________ Hospital:______________________ Diagnosis: __________________________

Any medication allergies? **Food Allergies?** **Please list.**

Please list all prescription medications you are taking at the present time:

Drug: **Dosage:** **Taken for what reason?**

Any over-the-counter medications, vitamins, herbs, supplements or natural remedies?

Serious Injuries/ Surgeries (please list all)	Date	YES	NO

Please circle all the weight related Risks or Diagnoses that you may have:

Name: ________________________________ **Date: ______________________**

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Abdominal Pains
Abnormal EKG
Abnormal Weight Gain
Anemia
Anorexia Nervosa (now or in the past)
Anxiety/adjustment disorder/stress
Arthritis
Asthma
Breast Cancer
Binge Eating patterns/disorder
Bulimia/Purging (exercise, laxatives, vomiting, diuretics)
Constipation
Cushing's Syndrome
Depression/dysthmia
Diarrhea
Diabetes (Starting at what age? ___________)
Dizziness
Fatigue
Fibromyalgia
Frequent Headaches
GERD or Heartburn
Glaucoma
Gout
Hip Pain/Knee Pain
High Blood Pressure or "Pre-Hypertension"
High Cholesterol or Triglycerides
Irritable Bowel
Low Back Pain
Low Blood Sugars
Low Testosterone
Menopause
Migraines (What medication do you use?_________)
Muscle Spasm
Nausea/Vomiting
Osteoporosis
Panic Attacks
Painful, heavy, or irregular menses
Plantar Fascitis
Polycystic Ovarian Syndrome
Pre-diabetes
Psoriasis
Sleep Apnea
Snoring
Swelling feet or ankles
Thyroid Disorder
Ulcer
Urinary Stress Incontinence

OB/Gynecologic History:

Number of Pregnancies: ____________ Vaginal Delivery or C-Section: ____
Any Gestational Diabetes? YES/NO Babies over 9 lbs? YES/NO If yes what were their weights? ________________________
Menstrual Onset: _______ yrs old Duration: _______ days Last menstrual period: _________
Do you have pain associated with menstral cycle? YES/NO Are menses heavy? ____________
Are you on Birth Control? YES/NO If yes, please list: ____
On Hormone Replacement Therapy? YES/NO If yes, please list: ____
When was your last Physical/ PAP? ____

Family History:

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative had any of the following:

Glaucoma:	YES	NO	Who: ______________________________
Asthma:	YES	NO	Who: ______________________________
Epilepsy:	YES	NO	Who: ______________________________
High Blood Pressure:	YES	NO	Who: ______________________________
Kidney Disease:	YES	NO	Who: ______________________________
Diabetes:	YES	NO	Who: ______________________________
Psychiatric Disorder:	YES	NO	Who: ______________________________
Heart Attack:	YES	NO	Who: ______________________________
Heart Disease:	YES	NO	Who: ______________________________
Stroke:	YES	NO	Who: ______________________________
Overweight/Obesity	YES	NO	Who: ______________________________

Name: ________________________________ **Date:** ______________________

Revised 6-1-11

Smoking Habits:

___ I have never smoked cigarettes, cigars, or a pipe.
___ I quit smoking _____ years ago and have not smoked since.
___ I quit smoking at least one year ago and now smoke cigars or a pipe w/out inhaling smoke.
___ I smoke approx _____cigarettes per day (_____ pack/s)

Activity Level (answer only one):

___ Inactive/ Sedentary- includes only the light physical activity associated with typical day-to-day life
___ Moderate Activity- includes physical activity equivalent to walking about 1.5 to 3 miles per day at 3 to 4 miles per hour (in addition to the light physical activity associated with typical day-to-day life)
___ Active- includes physical activity equivalent to walking more than 3 miles per day at 3 to 4 miles per hour, (in addition to the light physical activity associated with typical day-to-day life)

Please check all that apply to you currently

☐ Stress	☐ Temper	☐ Marriage
☐ Unhappiness	☐ Physical abuse	☐ Trauma/disaster
☐ Inferiority feelings	☐ Problems concentrating	☐ Trouble with job
☐ Fears	☐ Loss of control	☐ Children
☐ Depression	☐ Sexual problems	☐ Nervousness
☐ Anger	☐ Death	☐ Emotional abuse
☐ Racing thoughts	☐ Pregnancy	☐ Anxiety
☐ Friends	☐ Making decisions	☐ Guilt
☐ Impulsive behavior	☐ Parenting	☐ Grief
☐ Ambition	☐ Unwanted thoughts	☐ Loneliness
☐ Finances	☐ Abortion	☐ Memory loss
☐ Panic	☐ Shyness	☐ Compulsivity
☐ Apathy	☐ Communication	☐ Legal matters
☐ Hopelessness	☐ Sexual abuse	
☐ Alcohol use	☐ Bad dreams	

Please indicate your level of **motivation to lose weight** on the scale below:

0	**5**	**10**
Unmotivated	**Neutral/Unsure**	**Very Motivated**

Do you have any interest in getting more information about how the other specialties in our clinic may enhance or assist you in your weight loss? (Please circle all that apply):

Nutritional Counseling - Acupuncture - Medi-Spa - Physical Therapy - Massage Therapy - Mental Health/ Counseling - Personal Training

Signature:____

Mood Assessment Checklist

Name: **Date:**

(ANSWER AS YOU'VE BEEN FEELING ON YOUR <u>CURRENT MEDICATION</u> DURING THE PAST <u>2 WEEKS</u>)

Elevated Mood ? (Not at all . . . . Extremely)	0	1	2	3	4
I have much more energy than usual	☐	☐	☐	☐	☐
I feel unusually euphoric and "high"	☐	☐	☐	☐	☐
I am irritable and short-tempered	☐	☐	☐	☐	☐
I have a heightened interest in sex	☐	☐	☐	☐	☐
My thoughts are speeded up (or racing)	☐	☐	☐	☐	☐
____ / 20					

Depressed Mood ? (Not at all . . . . Extremely)	0	1	2	3	4
I feel sad, blue, or downhearted	☐	☐	☐	☐	☐
I have feelings of helplessness	☐	☐	☐	☐	☐
I have crying spells (or feel like it)	☐	☐	☐	☐	☐
I feel hopeless about the future	☐	☐	☐	☐	☐
I've lost interest or pleasure in things	☐	☐	☐	☐	☐
I have a low energy level	☐	☐	☐	☐	☐
I feel guilty or worthless or both	☐	☐	☐	☐	☐
My appetite has increased (or decreased)	☐	☐	☐	☐	☐
My memory has gotten bad	☐	☐	☐	☐	☐
It has become hard to concentrate	☐	☐	☐	☐	☐
____ / 40					

Thoughts of Suicide ? (Not at all . . . . Extremely)	0	1	2	3	4
I often wish I were dead	☐	☐	☐	☐	☐
Others would be better off without me	☐	☐	☐	☐	☐
I think about various ways to end my life	☐	☐	☐	☐	☐
I've settled on a specific plan for suicide	☐	☐	☐	☐	☐
I have decided to commit suicide	☐	☐	☐	☐	☐
____ / 20					

Vegetative Features ? (Not at all . . . . Extremely)	0	1	2	3	4
I sleep too much	☐	☐	☐	☐	☐
I am often in bed or on the couch	☐	☐	☐	☐	☐
My housekeeping has deteriorated	☐	☐	☐	☐	☐
I spend most of my time alone	☐	☐	☐	☐	☐
My personal hygiene has fallen off	☐	☐	☐	☐	☐
____ / 20					

Agitated Features ? (Not at all . . . . Extremely)	0	1	2	3	4
I pace, fidget, or am unable to sit still	☐	☐	☐	☐	☐
I have been irritable or cranky	☐	☐	☐	☐	☐
I yell at or argue with family or others	☐	☐	☐	☐	☐
I am having outbursts of anger	☐	☐	☐	☐	☐
I have thoughts of harming others	☐	☐	☐	☐	☐
____ / 20					

Distressing or Peculiar Thoughts ? (Not at all . . . . Extremely)	0	1	2	3	4
People are watching or talking about me	☐	☐	☐	☐	☐
Others are aware of my private thoughts	☐	☐	☐	☐	☐
I hear voices that others do not hear	☐	☐	☐	☐	☐
I see things that are not really there	☐	☐	☐	☐	☐
Someone else can control my thoughts	☐	☐	☐	☐	☐
____ / 20					

Difficulty Sleeping ? (Not at all . . . . Extremely)	0	1	2	3	4
I have trouble getting to sleep	☐	☐	☐	☐	☐
I wake repeatedly during the night	☐	☐	☐	☐	☐
I awaken too early in the morning	☐	☐	☐	☐	☐
I've gone for days with nearly no sleep	☐	☐	☐	☐	☐
I sleep more than eight hours each night	☐	☐	☐	☐	☐
____ / 20					

Social Anxiety ? (Not at all . . . . Extremely)	0	1	2	3	4
I am uncomfortable in social situations	☐	☐	☐	☐	☐
I am intimidated by people in authority	☐	☐	☐	☐	☐
I fear embarrassing myself in public	☐	☐	☐	☐	☐
I get panicky when in social situations	☐	☐	☐	☐	☐
I avoid going to parties	☐	☐	☐	☐	☐
I avoid being the center of attention	☐	☐	☐	☐	☐
Being criticized scares or angers me	☐	☐	☐	☐	☐
I avoid having to give speeches	☐	☐	☐	☐	☐
I'd do anything to avoid being criticized	☐	☐	☐	☐	☐
Talking to strangers scares me	☐	☐	☐	☐	☐
____ / 40					

Obsessive Features ? (Not at all . . . . Extremely)	0	1	2	3	4
I tend to worry excessively	☐	☐	☐	☐	☐
I tend to be a perfectionist	☐	☐	☐	☐	☐
I do tasks slowly to insure accuracy	☐	☐	☐	☐	☐
I fret about germs & contamination	☐	☐	☐	☐	☐
It is often hard to make decisions	☐	☐	☐	☐	☐
____ / 20					

Compulsive Features ? (Not at all . . . . Extremely)	0	1	2	3	4
I tend to check and re-check things	☐	☐	☐	☐	☐
I bite my nails, or pull at my hair	☐	☐	☐	☐	☐
I wash my hands or bathe excessively	☐	☐	☐	☐	☐
I need to count things repeatedly	☐	☐	☐	☐	☐
I must keep things neat and clean	☐	☐	☐	☐	☐
____ / 20					

Panic Anxiety ? (Not at all . . . . Extremely)	0	1	2	3	4
Episodes of intense fear or a sense of "impending doom"	☐	☐	☐	☐	☐
During these episodes I have the following:					
Palpitations, pounding or fast heart rate	☐	☐	☐	☐	☐
Sweating, trembling or shaking	☐	☐	☐	☐	☐
Shortness of breath / smothered feeling	☐	☐	☐	☐	☐
Chest pain or discomfort	☐	☐	☐	☐	☐
Feeling dizzy, lightheaded or faint	☐	☐	☐	☐	☐
Fear of losing control or of dying	☐	☐	☐	☐	☐
Numbness,tingling or feeling of unreality	☐	☐	☐	☐	☐
Chills or hot flushes or nausea	☐	☐	☐	☐	☐
Persistent concern about more attacks	☐	☐	☐	☐	☐
____ / 40					

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If you answered "YES" to 4 or more of these questions, you may have a sleep disorder. Please contact Oregon Sleep Specialists at 866-285-4245 to schedule a consultation with a board certified sleep specialist.

SNaG™
(SNoring and Gasping)

Questionnaire

Name: ______________________ Date of Birth: ___________

	YES	NO
1. Do you snore at night?	☐	☐
2. Do you stop breathing, choke or gasp during sleep?	☐	☐
3. During your daytime, are you tired, sleepy or fatigued?	☐	☐
4. Are you overweight (BMI greater than 28, see reverse for calculation)?	☐	☐
5. Is your neck circumference greater than:		
Women – 16 inches	☐	☐
Men – 17 inches	☐	☐
6. Do you have high blood pressure?	☐	☐

ADAM Questionnaire (Low Testosterone Questionnaire)

If you are concerned that your testosterone level is low, these ten questions are a good start.

	Answer YES or NO to each of the following questions:	**Yes**	**No**
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

If you answered YES to questions 1 or 7 or any 3 other questions, you may be experiencing androgen deficiency (low testosterone level). ***Adapted from Morley, et al. Validation of a screening questionnaire for androgen deficiency in aging males. Metabolism. 2000;49(9): 1239-1242*