## Weight Intake Form

**Welcome! To customize a plan just for YOU, it helps us to have some more details.**

**Please fill out this questionnaire before your visit so we can make the most of our time together.**

### Weight History

What has your weight been like over time? Draw a chart. Note anything you feel has been significant to help you lose weight or reasons you might have gained weight.

Weight

Year or Event

**WHY do you want to lose weight?**

**Have there been things that have helped you lose weight in the past?**

**Have you ever participated in any formal diet programs (e.g. Noom, Weight Watchers, Jenny Craig)? If so, when/how long?**

**Do you have times when you eat more than you plan and feel out of control? If so, how often?**

**Please answer “yes” or “no”.**

Do you snore?

Do people tell you that you stop breathing in your sleep?

Do you have headaches in the morning?

Are you constantly sleepy?

Can you fall asleep anywhere?

**Are you interested in medications to help you lose weight?**

Not Interested Very Interested

1 2 3 4 5 6 7 8 9 10

**How confident are you that you will be able to lose weight?**

Not Confident Very Confident

1 2 3 4 5 6 7 8 9 10

### What does a typical day of eating look like for you?

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

Drinks:

What about weekends and special occasions?

How often do you get fast food or eat out at restaurants?

What type, if any, exercise do you currently do?

### Are there any foods you CANNOT eat?

|  |  |  |
| --- | --- | --- |
| **To better guide us to choose weight loss medication options, do you have? (Y/N)** | | |
|  | **Y** | **N** |
| History of heart disease? |  |  |
| History of glaucoma? |  |  |
| Intolerance to caffeine/stimulants? |  |  |
| Anxiety? |  |  |
| History of kidney stones? |  |  |
| History of severe migraines? |  |  |
| History of depression? |  |  |
| History of seizures? |  |  |
| Any tobacco use? |  |  |
| Uncontrolled hypertension? |  |  |
| Any recreational drug use? |  |  |
| Currently taking opioids (e.g. morphine, hydrocodone) or have any upcoming procedures/surgeries? |  |  |
| Any alcohol intake? (How much per week) |  |  |
| History of diabetes, prediabetes, or gestational diabetes? |  |  |
| History of pancreatitis or gallbladder disease? |  |  |
| History or Family History of thyroid cancer? |  |  |
| History or Family History of endocrine neoplasia? |  |  |
| General fear of needles or self-injections? |  |  |
| Currently pregnant or attempting to conceive? |  |  |
| Breastfeeding? |  |  |
| If sexually active, are you using contraception? |  |  |