Weight Management Patient History Questionnaire

*The information requested below is very important. To give you the best care, we must have complete and **honest** answers. Please be thorough and print clearly with black ink. Thank you.*

Patient Name: _____ **Date of Birth:** _____

Please record current home values below. If you do not have a blood pressure cuff, use your last recorded vitals.

Height: _____ (Feet/Inches) **Weight:** _____ (Pounds) **Blood Pressure:** _____ **Heart Rate:** _____

WEIGHT HISTORY - *Please estimate as closely as possible for all that applies.*

Life Events	Age	Weight
Lowest weight in past five years		
Highest weight in past five years		
Weight one year ago		
Other:		

What is your Goal Weight? _____

Do you use a home scale? ☐ No ☐ Yes **How often do you weigh yourself?** _____

Have you had bariatric surgery? ☐ No ☐ Yes

If No, are you interested in learning more about bariatric/weight loss surgery? ☐ No ☐ Yes

If Yes, which procedure and when? ☐ LapBand ☐ Gastric Bypass ☐ Gastric Sleeve **Date:** _____

What is motivating you to seek this type of intervention for weight control and/or loss?

_____

SOCIAL HISTORY

Do you use any tobacco? ☐ No ☐ Yes **Do you vape?** ☐ No ☐ Yes

If Yes, what? _____

How often/much? _____

Do you drink alcohol? ☐ No ☐ Yes

If Yes, what kind/how much/often? _____

Any drug use? ☐ No ☐ Yes

If Yes, what type/how much/often? _____

History of drug overdose? ☐ No ☐ Yes

If Yes, when? _____

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FAMILY HISTORY

Is there obesity in the family? ☐ No ☐ Yes

If Yes, please list: _____

Are there any medical illnesses in your immediate family? ☐ No ☐ Yes

Diabetes?	☐ No ☐ Yes	Who: _____	Type: _____
Hypertension?	☐ No ☐ Yes	Who: _____	Type: _____
Coronary Artery Disease?	☐ No ☐ Yes	Who: _____	Type: _____
Cancer?	☐ No ☐ Yes	Who: _____	Type: _____
Other: _____		Who: _____	Type: _____

WEIGHT LOSS ATTEMPT HISTORY

Please list ALL weight loss attempts, physician-supervised programs, as well as self-monitored diets. Please take the time to be as thorough as possible.

Age you first started dieting: _____

Type of diet (ex: Keto Diet, Jenny Craig, Weight Watchers, weight loss medication, etc.):

List any other physician-supervised and documented weight-loss attempt(s):

Weight Management Patient History Questionnaire

FOOD INTAKE

What specific food plan/diet are you currently following, if any? _____

How many meals do you consume per day? _____

Do you skip meals? ☐ No ☐ Yes Number of snacks per day: _____

Do you eat breakfast? ☐ No ☐ Yes

How late is your dinner? _____ When is your typical bedtime? _____ Do you snack after dinner? _____

Do you snack between meals? ☐ No ☐ Yes

If so, what and how often? _____

Do you have any eating related problems or concerns? ☐ No ☐ Yes

If Yes, please explain: _____

Are you willing to cook, or do you prefer purchasing meals? _____

Do you have any diet restrictions?

Vegetarian? ☐ No ☐ Yes

Gluten Free? ☐ No ☐ Yes

Other? _____

What is your daily protein intake from drinks and/or food? _____

How much **WATER** do you drink in a 24-hour period?

☐ 24oz (3 cups or less) ☐ 32oz (4+ cups) ☐ 64oz (8+ cups) Other: _____

What do you drink other than water? _____ How much? _____

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	Place	Food/Beverage	Amount
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

PHYSICAL ACTIVITY

Do you exercise regularly? ☐ No ☐ Yes If yes, do you have an exercise regimen? Please list in table below.

Do you have any physical restrictions that keep you from exercising? ☐ No ☐ Yes

If yes, explain: _____

Type of Physical Activity (Walking, Yoga, Cardio, Weights, Swim, etc.)	Intensity (Light, Medium, or High)	Daily?	How Often?	Comments
		☐ No ☐ Yes		
		☐ No ☐ Yes		

PERSONAL MEDICAL HISTORY Do you have or have you had any of the following? Check all that apply.

Psychological

Do you have any of the following? (Please check all that apply)

☐ Depression ☐ Panic Attacks ☐ Anxiety ☐ Bipolar Disease ☐ Eating Disorder

☐ Obsessive Compulsive Disorder ☐ Other: _____

Seeking treatment? ☐ No ☐ Yes

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Do you have a history of suicide attempt or suicidal ideation? ☐ No ☐ Yes

If so, when? _____

Are you currently seeing a psychologist/psychiatrist/therapist? ☐ No ☐ Yes

Sleep Health

How many hours do you typically sleep per night? _____ hours

If you have insomnia, do you have trouble falling asleep or staying asleep? ☐ No ☐ Yes

Has anyone told you that you snore loudly or stop breathing for a few seconds during sleep? ☐ No ☐ Yes

Do you have excessive daytime sleepiness? ☐ No ☐ Yes

Have you been diagnosed with Sleep Apnea? ☐ No ☐ Yes

If yes, are you currently on CPAP or other oral device? ☐ No ☐ Yes

Cardiovascular

High blood pressure ☐ No ☐ Yes

If yes, medication? ☐ No ☐ Yes (Please list under medications - page 6)

Heart attack? ☐ No ☐ Yes When? _____

Heart bypass surgery? ☐ No ☐ Yes When? _____

Stents? ☐ No ☐ Yes When? _____

Pacemaker? ☐ No ☐ Yes When? _____

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Endocrine

Diabetes? ☐ No ☐ Yes **If yes, do you have low sugar episodes?** _____

If yes, please write your current A1C blood test value, if known: _____

If yes, medication? ☐ No ☐ Yes (Please list under medications - page 6)

Thyroid problems? ☐ No ☐ Yes **When?** _____

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Gastrointestinal

Heartburn? ☐ No ☐ Yes **If yes, how often a week?** _____

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Do you get pain in your upper abdomen after eating or in the middle of the night, other than heartburn? ☐ No ☐ Yes

Have you ever been told you have gallstones? ☐ No ☐ Yes

Have you ever been told you have a fatty liver? ☐ No ☐ Yes

Respiratory

Do you have asthma? ☐ No ☐ Yes

Do you have COPD/Emphysema? ☐ No ☐ Yes

If yes, medications? ☐ No ☐ Yes (Please list under medications - page 6)

How far can you walk before you get short of breath? _____

Musculoskeletal

Do you have joint pain? ☐ No ☐ Yes **If yes, where?** _____

Do you take medications for this? ☐ No ☐ Yes (Please list under medications - page 6)

Have you seen an Orthopedic MD for this? ☐ No ☐ Yes

Have you had surgery for this? ☐ No ☐ Yes

If yes, when and what? _____

Are you waiting for a joint replacement until you lose weight? ☐ No ☐ Yes

Gynecologic and Obstetric

Age at onset of periods: _____ **Frequency:** _____ **Length of Period:** _____

Pregnancies: _____ **Births:** _____ **Miscarriages:** _____

Prolonged or abnormal bleeding? ☐ No ☐ Yes **If yes, describe:** _____

Any other medical history/conditions besides listed above? (Include Medication/Food Allergies)

Weight Management Patient History Questionnaire

MEDICATIONS (Including vitamins - please attach medication list if applicable)

☐ I do not currently take any medications

Medication	Dosage	Frequency	Comments

☐ I certify that all the information that I provided on this questionnaire is true, accurate, and complete.

Weight Loss Intake

Please complete all sections. The patient, if an adult is regarded as being responsible for all charges generated.

Date: _____ **Social Security #:** _____

Patient Name: ☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. _____ _____
First Last

Current gender identity: _____ **Sex assigned at birth:** _____ **Preferred pronoun(s):** _____

Date of Birth: _____ **Age:** _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell:** _____ **Work Phone:** _____

Email: _____ **Pharmacy:** _____

Emergency contact: _____ _____
First Name Last Name

Relationship to Patient: _____ **Phone:** _____

Primary Care Physician: _____

☐ **I authorize the release** of any medical information to any physicians involved in my care.

☐ **I do not authorize** Inspire Medical Group to release my medical records.

Please Note: We do not accept insurance for the weight loss program.

HIPAA Consent Form

Use and Disclosure of Protected Health Information

I give my consent for this organization to contact me by calling my home/mobile or other designated location in order to leave a message whether mechanically or with another person, or to speak to me directly regarding any matter which may help with the conduct of **Treatment, Payment, or Healthcare Operations**.

Please update the following information for your records:

Phone Number: _____

Best time to call: _____

Email: _____

Preferred method of contact (please check one):

- ☐ Text
- ☐ Phone
- ☐ Email

Client Name: _____

Client Signature: _____ **Date:** _____

Nobles Weight Loss Clinic Disclaimer

1. The staff at Nobles Weight Loss Clinic will provide the tools you need to achieve the weight loss goal that YOU set to yourself. We will offer the best advice that we can give and add some little "tricks'' that we have either learned from personal experience or from the many clients who have shared their helpful hints with us. **Initial:** _____
2. We offer no magic potions, but we will educate you on some supplements which we have found to be helpful to some clients. We will not upsell you on any products that are not relative to you reaching your goal. **Initial:** _____
3. The program is made up of the following: The client's desire to lose weight, improve their health and the willingness to make the necessary lifestyle changes to achieve their goal and maintain that goal. **Initial:** _____
4. The tools that we provide include a diet manual, accompanied by the appropriate recipes included in the guide, exercise suggestions, a B12 injection once per month, lots of support and ideas on a weekly basis as we track your progress. **Initial:** _____
5. The staff will share some little tricks to help you learn from day one how to keep the weight off. We do not believe that clients "cheat", we call it "living". It is not necessary to feel like you have lost all progress if you have a big party to go to or some bad days which ended up with some comfort foods. Those days will happen and as long as it is not day after day, it is easy to "offset" those days. We will teach you what to do while you are in the "dieting phase" so that once you reach your goal you will have already practiced and become comfortable with the remedies to help you maintain your desired weight. **Initial:** _____
6. We would much appreciate having Before and After pictures of you to share in our marketing efforts. If you are not comfortable with this please write "NO" at the end of this paragraph. It is not a requirement. If you are so inclined, we would appreciate sharing your personal progress on Facebook, Instagram, and other relevant social media sites. **Initial:** _____
7. To justify the use of weight loss enhancers, the patient must have a Body Mass Index (BMI) of 30 or above, or a BMI greater than 26 with at least one comorbidity factor, or a measurable body fat content equal to or greater than 25% of total body weight for male patients or 30% of total body weight for women. **Initial:** _____ **Counselor:** _____

Please CHECK if you have any of the following:

- ☐ Cardiovascular disease
- ☐ Chronic Lung Disease
- ☐ Myocardial Infarction (MI)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Hypertension (HBP)
- ☐ Emphysema

Client Signature: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

Informed Consent: Semaglutide / Tirzepatide for Weight Loss

Semaglutide is a GLP 1 Receptor. It mimics the action of a hormone called Glucagon-Like Peptide (GLP). Glucagon is the storage form of carbohydrates, which is a factor in weight gain. Glucagon causes stored carbohydrates to break down and move into the bloodstream for metabolism. Glucagon decreases carbohydrate absorption from the gut while decreasing appetite by slowing gastric mobility. When blood sugar rises after eating, these drugs stimulate the body to produce more insulin. The extra insulin helps lower blood sugar. The lower blood sugar levels help control type 2 Diabetes. Tirzepatide affects two receptors (dual action), acting on both GIP (glucose insulinotropic polypeptide) and GLP-1 receptors (glucagon-like peptide). This dual response further increases safety and decreases hunger. Combined with a sensible diet and healthy lifestyle changes, Semaglutide and Tirzepatide effectively reduce body weight. Semaglutide and Tirzepatide curb appetite and slow food movement from the stomach to the small intestines. As a result, clients feel full longer and subsequently eat less, leading to weight loss.

Further studies have demonstrated that GLP-1 and SGLT-2 (sodium-glucose transport protein 2) inhibitors may reduce the risk of heart disease, heart failure, stroke, and kidney disease. Many clients prescribed these medications have seen blood pressure and cholesterol levels improve.

Side Effects

Like most prescription drugs, both Semaglutide and Tirzepatide can have moderate to severe side effects in some users.

- Abdominal pain (most common)
- Redness
- Constipation
- Dizziness
- Nausea
- Belching
- Diarrhea
- Vomiting
- Injection site reactions
- Blurred vision
- Headache
- GERD
- Depression; confusion; mood changes
- Gall Bladder pain with pre-existing cholelithiasis or gallstones
- Irritability
- Hair Loss
- Complications with anesthesia

Initials: _____

Hypoglycemia (low blood sugar) has been linked to GLP-1 medications when combined with insulin or sulfonylureas.

Any severe abdominal pain, vomiting, or constipation should be reported to the Inspire Medical Group staff for referral to our Medical Director for guidance.

Informed Consent: Semaglutide / Tirzepatide for Weight Loss

Medications

Initial Health Assessment will review all medications before clearance for participation in a GLP-1 Weight Loss Program. Do you take any of the following medications? Please check if currently prescribed:

- ☐ **Amaryl**
- ☐ **Glimepiride**
- ☐ **Glucotrol**
- ☐ **Glipizide**
- ☐ **Glipizide ER**
- ☐ **Glynase**
- ☐ **Tolbutamide**
- ☐ **Tolazamide**

Warnings

Effects on Birth Control and Pregnancy
GLP-1 medications may affect the efficacy of oral contraceptives and birth control shots. Clients using oral birth control medications and birth control shots are strongly encouraged to use an alternative birth control plan while enrolled in GLP-1 Weight Loss Programs.

Pregnancy
Clients who are pregnant or attempting to become pregnant should stop using these medications. Animal studies have shown that these agonists may reduce embryo size and may cause developmental abnormalities.

Anesthesia
Clients scheduling any surgical procedure involving anesthesia must stop using GLP-1 medications at least two weeks before the procedure. Clients should notify anesthesiologists that they have been prescribed GLP-1 medications.

Initials: _____

Exclusions from GLP-1 Weight Loss Programs
Clients diagnosed with one or more of the following conditions may not participate in GLP-1 Weight Loss Programs. Please review this list carefully and check any pre-existing conditions.

- ☐ **Medullary Thyroid Cancer**
- ☐ **Pancreatis**
- ☐ **Gastroparesis**
- ☐ **Multiple Endocrine Neoplasia (all types, tumor or mass lesion)**
- ☐ **Hepatobiliary disease (GB disease)**
- ☐ **Abnormal liver function tests**

Please initial here if, to the best of your knowledge, you are **free** of all the above medical conditions.

Initials: _____

Following a thorough review of your health assessment, our Medical Director will make the final determination for full participation in the GLP-1 Weight Program.

Initials: _____