Name: ___________________________ Date of Birth:___________________

Welcome!
We are glad you are taking the next step of your weight loss journey with us.
Please complete the following for us to be able to make the most out of your first visit.

Please list other additional physicians you see:
Psychiatrist/Psychologist: ____
Address: ____
Phone: _________________________________

Orthopedic: ____
Address: ____
Phone: _________________________________

Ob/Gyne: ____
Address: ____
Phone: _________________________________

How did you hear about our practice?
Friend Family Doctor Internet I am a current patient
Other______________________

What weight loss options are you interested in?
Anti-obesity Medication Food Supplementation/Meal Replacement
Dietary Advice/Counseling Unsure

North Shore Primary Care and North Shore Bariatric Medicine
1900 Hollister Drive Suite 250
Libertyville, IL 60048
(847) 573-9663 phone (847) 573-9662 fax
Email: office@northshoreprimarycare.com

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Habits

Do you drink caffeine? Yes No

Type: Coffee (___ cups/day) Soda (___cups/day) Tea (___cups/day)

Do you use any of the following? Yes No

Type: Cigarettes (___/day) Marijuana (___/week)

Cocaine (___/week) Heroin (___/week) Other: _____________________

Weight Loss History

Highest Adult Weight: ________________

Lowest Adult Weight: _________________

Goal Weight: ______________

My weight problem started:

in childhood at puberty as an adult after pregnancy

after a traumatic event other: __________________

***Additional notes regarding the onset of weight gain:**

Eating Habits (circle or select the applicable)**:**

Binge eater (at night, or after getting home from work, before bed)

Emotional eater

Night eater

Snacker/Grazer

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Do you? (circle or place a check next to the appropriate selection)

1. Overeat (Overeating is when you plan to eat a "normal" amount and you overeat but not to the point of feeling like you may vomit.) Y N
2. Overindulge (Overindulgence is when you plan to eat too much but not to the point of wanting to vomit) Y N
3. Binge (Binge eating is defined as eating a large amount of food during a short amount of time, typically no more than 2 hours, while feeling out of control and the inability to stop eating even though you should) Y N
4. Do you purge (make yourself vomit after a meal): Y N

Weight Loss Programs/Diets/Medications:

Diet Program	Year & Duration	Total Weight Loss	Documentation Available? Y or N
Atkins/Zone			
Jenny Craig			
Weight Watchers			
Opti/Medi Fast			
HCG/Relena			
Nutri System			
Metabolife			
Dietitian/nutritional counseling			
Phentermine or Fen-Fen			
Robard, Healthwise, HMR, VLCD			
"Fad diets" i.e. Keto, Paleo			
Medically managed weight loss program			

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Have you been on any type of steroid in the last 12 months? Y N

Exercise History

Are you currently participating in a regular exercise program? Y N

Do you have physical limitations that make activity difficult? Y N
If yes, please explain:

____

Do you have concerns regarding exercise and physical activity? Y N
If yes, please explain:

____

Exercise History for the Past 12 Months:

Type of Activity (walk/run/swim/bike/yoga/dance/etc.)	Start Date	End Date	How many times per week you were doing this activity

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How far can you walk without having difficulty?
< 1 block < ½ mile < 1 mile > 1 mile

When you go past this distance, what limits your ability to continue?

How many stairs can you climb without difficulty? _______________________________

Women Only:

Age your menstrual cycles began: ____________________

Have you been diagnosed with?
Polycystic ovarian syndrome (PCOS): Y N

Date of your last menstrual period: ___________________

Are your menses regular? Y N

Are you using birth control? Yes, type: _________________ N

Number of pregnancies: ______________ Number of live births: ________________

Are you experiencing menopausal symptoms? Y N

Have you completed menopause? Y N
Age: ___________

Are you on hormone replacement therapy? Y N

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Additional Health/Medical Information:

Please circle if you have or have had any of the following medical conditions:

Acid Reflux
Alcoholism
Allergies
Angioplasty
Anxiety
Bladder infections
Bleeding disorder
Blood transfusions
Bowel incontinence
Breathing issues/Shortness of Breath
Bulimia/Excessive Vomiting
Colitis
Constipation
COPD
Currently on blood thinners
Depression

Diabetes Mellitus
Diverticulitis
Deep Vein Thrombosis (DVT)
Easy bruising
Frequent nausea
Gallbladder (stones, colic, etc.)
Gout
Heart failure
Heart surgery or stents
Heart disease
Hemorrhoids
Hernia
High cholesterol
HIV/AIDS
Irritable bowel
Kidney disease

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Functional Health Status:

Independent Partially Dependent Totally Dependent

Is your mobility limited?

Yes: all the time or some of the time No, never

Have you fallen in the last 12 months?

Yes, explain: ____ No

Were you injured in the last 12 months?

Yes, explain: ____ No

PLEASE RETURN FORMS BY FAX OR EMAIL PRIOR TO YOUR APPOINTMENT.

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