Weight Management Program

DIRECTIONS FOR COMPLETING THE QUESTIONNAIRE

Please complete this questionnaire as completely as possible, and bring it with you to your first appointment. Do not leave any section of the questionnaire blank. For example, if you have never had any surgery, fill in the surgery section with "none". Like all of your medical records, this information will be kept strictly confidential.

If you have any questions about this questionnaire, please call 218-894-8306.

Demographic Information:

Full name: _____

Date of birth: _____

Address: _____

_____

Home phone: _____ Work phone: _____

Current Weight: _____ pounds

Height: _____ feet _____ inches

Which weight loss treatments are you interested in exploring?

- ☐ Surgery
- ☐ Medications
- ☐ Surgery and medications
- ☐ Diet only
- ☐ Diet and exercise
- ☐ Exercise only

In what type of exercise would you be interested?

- ☐ Individual
- ☐ Group

MEDICATIONS

Medications to which you are allergic or intolerant

Are you allergic to any medications? Are there any medications you cannot take for whatever reason?

Name of medication	What happens when you take it?

Medications you are currently taking

Are you taking any medications? If yes, list them below. List all your medications whether you take them on a regular schedule or only now and then. Also, list all over-the-counter medications, even vitamins and other nutritional supplements.

Name of medication	Strength of medication	How many pills or how much medication do you take?	How often do you take the medication?	For what is the medication taken?

MEDICAL HISTORY (other than surgeries)

Year of diagnosis	Problem: *(Include neurological, eye, ear, nose, throat, thyroid, or other hormones, including diabetes, lymph node, lung, breast, stomach or intestines, kidneys or bladder, reproductive, gynecological, joints, skin, high blood pressure, high cholesterol and anything else you feel is relevent.)*

Do you have any history of heart problems? If so, please describe. Do you regularly have chest pain, palpitations or any other symptoms you believe are due to your heart not working properly? Have you ever had a heart attack and/or stroke? If so, please describe the details of these events.

Year	Nature of problem	Treatment	Fully recovered?

Have you ever had a stress test for your heart? If so, when, and what were the results?

Year	Type of test	Results

Have you ever had a cardiac catheterization for your heart? If so, when, and what were the results?

Year	Type of test	Results

Have you ever had problems with bleeding after any surgery, procedure or injuries? If yes, please describe.

Year	Type of surgery/procedure	Results

That you're aware, have you ever had a severe reaction to an anesthetic drug? If so, please describe.

Medication	Reaction	Treatment

Are you wheelchair-bound? ☐ No ☐ Yes

If yes, please describe why: _____

Are you on home oxygen? ☐ No ☐ Yes

If yes, please describe why: _____

Are there any religious and/or other reasons that would bar you from accepting blood transfusions or any other medical intervention? ☐ No ☐ Yes

SURGERY

Have you ever had ANY kind of surgery, including gynecological operations such as C-sections, tubal ligations and hysterectomy?

If you have, please give details in the table below.

Year	Type of surgery *Tell if you had an incision or if it was "minimally-invasive" or "laparoscopically"*	Why was surgery done? *(If not obvious.)*	Are you completely healed, or are you still having problems either from surgery or from the problem the surgery was intended to help?

SEVERE INJURIES

If you have already given information about an injury under the SURGERY section, you do not need to repeat it here.

Year	Nature of injury	How was the injury treated?	Are you completely recovered?

SEVERE INJURIES

Again, if you have already given information about a condition or event in a previous section, you do not need to repeat it here.

Year	Reason of hospitalization

MENTAL HEALTH

Year	Diagnosis

If you see or have recently seen a psychologist or psychiatrist, or been in an eating disorder or chemical dependency treatment program, please bring the names, addresses, and phone numbers for these to your appointment.

HEALTH HABITS

Do you use **tobacco** (including smokeless)? ☐ No ☐ Yes

If you do: How much? _____

How long have you been a smoker? _____

How long have you used smokeless tobacco? _____

If you don't use tobacco (including smokeless) now, have you ever? ☐ No ☐ Yes

How much did you use? _____

How long had you been a smoker before you quit? _____

When did you quit? _____

Why did you quit? _____

Do you drink **alcohol/beer**? ☐ No ☐ Yes

If yes, _____ drinks per week, or _____ per month.

Do you use any **recreational drugs** (other than tobacco or alcohol)? ☐ No ☐ Yes

If you do: What drugs do you use? _____

How much? _____

How often? _____

If you don't use drugs now, have you ever? ☐ No ☐ Yes

What drugs? _____

How much? _____

How often? _____

Have you ever received treatment for drug abuse or addiction? ☐ No ☐ Yes

How long have you been sober or drug-free? _____

Is there an **exercise** routine that you follow? ☐ No ☐ Yes

If so, what do you do? _____

How often? _____

How long? _____

FAMILY MEDICAL HISTORY

If you know about the health history of your biological parents, brothers and sisters (if any), please complete the table below.

Relationship	Living or deceased (circle one)	Age now or at death	If deceased, cause of death	Any diabetes, heart attack or stroke under 60; high cholesterol; cancer; alcoholism; serious psychological illness or severe obesity?
Father	*Living/deceased*			
Mother	*Living/deceased*			
Bro/Sis	*Living/deceased*			
Bro/Sis	*Living/deceased*			
Bro/Sis	*Living/deceased*			
Bro/Sis	*Living/deceased*			

SOCIAL

Marital status:

☐ Never married
☐ Married
☐ Committed relationship without marriage
☐ Separated
☐ Divorced
☐ Widowed

Do you have children?

Gender (circle one)	Age
Male/Female	
Male/Female	
Male/Female	
Male/Female	
Male/Female	

Occupation: _____

Full or part time (circle one)

Disabilities? ☐ No ☐ Yes What is your disability? _____

Are you on SSD/SSI? ☐ No ☐ Yes

OBESITY HISTORY

Please list in the table on the next page, the most important events in your life that are related to obesity. Start with the earliest recollection you have of how being overweight was a problem for you, up to the present. List your age, or the date of the event, your weight at the time, if you remember it, and how your weight affected the event or how the event affected your weight.

Examples might include:

- At age 8, I was teased in school because I was chubby, and had a hard time finding clothes and taking part in physical education.
- I got pregnant for the first time at age 18. Before I got pregnant, I weighed 120 lbs. Just before I delivered, I was up to 180 lbs. During the eight months after delivery, I went down to 170 lbs.
- When I was 24, I had a bad back injury at work and was laid up for six months. I was very inactive, and went from 220 lbs. to 260 lbs.
- When I was 30, I weighed 300 lbs. and my doctor discovered I had developed diabetes.
- In 1999, I went to Weight Watchers for the first time. I weighed 260 lbs. I worked hard at it and lost about 40 lbs. over a year, but then got bored with it, and dropped out. Two years later, I'd regained to 270 lbs.

In short, include any significant health-related or social event that caused increased problems with weight, or any increase in weight that caused social or medical problems for you.

On the following page, please list all of your significant efforts at weight control, including:

- Times you used over-the-counter or prescription weight control medications or supplements.
- Times you participated in commercial programs like Weight Watchers, Optifast, Jenny Craig, or others.
- Times you received counseling from a nurse, dietitian or medical provider for weight control.

Year or age	Weight at beginning of event	Weight at end of event	Event

EATING HABITS

1) Which of the following do you eat/drink? Please fill in the table and indicate the amounts you eat in any given day or week. Indicate the number of:

Cups - one cup is the size of your fist

Tablespoons - two tablespoons is about the size for a golf ball

Teaspoons - one teaspoon is the size of the tip of your thumb or a dice

Ounces - one ounce is about the size of your whole thumb (three ounces = deck of cards)

Food	Portion size	Amount per day	OR	Amount per week
Beverages				
Regular soda (sugar-sweetened)/ Kool-Aid				
Sports drinks				
Fruit juice/lemonade				
Beer/wine/alcohol				
Cappuccino/latte/hot chocolate				
Milk - kind:				
Water				
Other:				
Sweets				
Ice cream/sherbet/frozen yogurt				
Cookies/cakes/pies				
Other:				
Proteins				
Hot dogs/bologna/sausage/bacon				
Beef				
Chicken/fish				
Cheese/cottage cheese				
Yogurt				
Other:				

Food	Portion size	Amount per day	OR	Amount per week
Fruits				
List all the fruits you eat:				
Vegetables				
List all the vegetables you eat:				
Grains				
Macaroni/noodles/rice				
Breakfast cereals				
Bread/English muffin/bagel				
Doughnut/danish/pastry				
Other:				
Combination foods				
Pizza				
Tacos				
Hot dish				
Soup				
Stir fry				
Other:				

2) During what period of time do you eat the most food? (Check all that apply.)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Late night

3) Which of the following best describes your eating pattern?

- ☐ 2-3 meals and no snack
- ☐ 2-3 meals with 1-2 snacks
- ☐ 2-3 meals plus evening grazing
- ☐ 1 meal
- ☐ Graze all day with no meal schedule
- ☐ Often wake up and eat during the night
- ☐ Other - Describe: _____

4) How often do you eat out?

- ☐ Once a month
- ☐ Once a week
- ☐ 2-4 times a week
- ☐ Daily
- ☐ Other - Describe: _____

5) At what type of restaurants do you eat? (Check all that apply.)

- ☐ Fast food
- ☐ Full service
- ☐ Buffets
- ☐ Coffee shops
- ☐ Cafeterias
- ☐ Other - Describe: _____

5) What do you see as your problem eating area(s)? (Check all that apply.)

- ☐ Snacking
- ☐ Food choices (high fat, fast food, fried, butter, sugared beverages, sweets)
- ☐ Portion sizes/portion control
- ☐ Grazing
- ☐ I don't know
- ☐ Other - Describe: _____

MOTIVATION TO TAKE ACTION IN MANAGING YOUR WEIGHT

To be successful in the medical Weight Management Program, you will need to make lifestyle changes, including changes in eating and exercise habits. You must also attend the initial Assessment Visit and all follow-up appointments.

On a scale from 1 to 10, with **1** being **not at all motivated**, and **10** being **extremely motivated**, please circle the most appropriate number to rate your motivation for the following at this time:

I am motivated to make changes in my eating habits.

1 2 3 4 5 6 7 8 9 10

I am motivated to make changes in my exercise habits.

1 2 3 4 5 6 7 8 9 10

I am motivated to attend all scheduled appointments for the Weight Management Program.

1 2 3 4 5 6 7 8 9 10

REFERRAL

Please ask your primary medical provider to send this referral sheet to Lakewood's Weight Management Program, or you may bring it with you to your appointment. They may also make a referral through your electronic health record. The purpose of the referral is to evaluate your weight problem (including, possibly, a medical evaluation, nutrition evaluation, and/or psychological evaluation), and to undertake treatment, including the possibility of treatment with diet, exercise, and medication, or with diet, exercise, and obesity surgery.

Patient name: _____

Provider name: _____

Clinic name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone number: _____

_____

Referring provider signature

Lakewood Health System Bariatrics
49725 Cty. 83
Staples, MN 56479

Phone: 218-894-8306

OBESITY TREATMENT INSURANCE WORKSHEET

This worksheet will allow you to find out, in advance, if your insurance company will cover obesity treatment at Lakewood. Please fill out this insurance worksheet BEFORE seeking obesity treatment. Even if your insurance company states they will cover our services, you may still need to pay all or part of the cost. If you need help, do not hesitate to contact us.

Your name: _____ Date of birth: _____

MEDICAL INSURANCE INFORMATION

(Complete this section BEFORE you call your medical insurance company.)
Policy holder's name and social security number (if you are not the policy holder)

Name: _____ Soc Sec No: _____

Insurance company name: _____

Location of insurance company (state): _____

Medical insurance policy number: _____

Group number: _____

Insurance company customer service phone number: _____

Ask the representative of your medical insurance company the following questions and write down the responses.

Name of the person with whom you spoke: _____

Direct phone number of person to whom you spoke: _____

Insurance company fax number: _____

Is your insurance coverage current?

☐ No ☐ Yes (If No, you will need to reestablish coverage before proceeding, or self pay.)

Is Lakewood Health System a network provider for your insurance?

☐ No ☐ Yes (If No, you might need to be evaluated through a different program.)

What is your coverage level? (This is the percent of the total charges your insurance company pays.)

☐ 100% ☐ 90% ☐ 80% ☐ Other_____

Deductible? _____