ProHealth
PRESCRIPTION WEIGHT LOSS

Patient intake form

DATE _____ **Name/age**_____ Birthdate_____

Primary Care Physician(PCP)_____ Have you discussed weight loss with your PCP? ____

Medication Allergies: _____None / Food allergies_____

Current Prescription or <u>over the counter medication or supplements</u> used (when needed and regularly) please list all:_____

_____

Past Medical History: (check all that apply) High blood pressure ❑ Diabetes ❑ high cholesterol ❑ heart murmur ❑ heart fluttering or palpitations ❑ sleep apnea/CPAP ❑ Thyroid problem ❑ glaucoma ❑ anxiety/depression ❑ back pain ❑ arthritis ❑ blood clots ❑ kidney problems ❑ kidney stones ❑ History of drug addiction or abuse ❑ Other:_____

Prior Surgical procedures/date_____

Family History: obesity ❑ diabetes ❑ heart disease ❑ high blood pressure ❑ high cholesterol ❑ Cancer/type_____ other_____

Occupation _____ **Smoker**_____ pack/day **Alcohol** drinks per week _____

Females: Last menstrual cycle_____ Birth Control method _____ Breastfeeding? _____

Number of pregnancies_____ Age of children _____ Gestational diabetes? _____

Prior Weight loss efforts: what and when _____

Medication used in the past for weight loss_____ When? _____

Any Side effects- please explain_____

Type of current exercise/frequency _____

Family members at home _____ Obesity in Family (who) _____

Who prepares meals_____ Who does grocery shopping_____

Average hours of sleep at night _____ Lifestyle: sedentary____ Moderately active _____Active_____

Pounds of weight loss desired? _____# How motivated are you? 1 (low) to 10 (extremely) ____

What are your perceived barriers to weight loss? _____

Patient Signature: _____ dmp 52017