WEIGHT MANAGEMENT PROGRAM

Welcome to the clinic! Help us help YOU by completing these forms. If you have question(s) about an item, leave it blank and ask the physician.

*Please ALSO complete the general clinic forms. When there are duplicate areas (e.g.: "Family Medical History"), fill out THIS form and leave it blank on the other one. **Thank you so much!** *[Revised 04 Sept 2021]*

Name: _____ Date of Birth: _____

PERSONAL GOALS (working with our clinic): Select **ANY/ALL** that apply to you

☐none; not sure

☐Improve health *(e.g., feel better, improve mobility, decrease medications, lower blood pressure, lower blood sugars, etc.)*

☐Prevent disease(s) *(e.g., diabetes, heart disease, etc.)*

☐Achieve a specific weight target: *(fill-in-blank)* _____ pounds

☐Become eligible for a specific surgery *(e.g., knee replacement)*: *(fill-in-blank)* _____

☐Other (specify – e.g., increase fertility): *(fill-in-blank)*

_____

BARRIERS (to achieving health/weight goals): Select **ANY/ALL** that apply to you

☐none; not sure

☐Diet (e.g., dietary knowledge, food choices, portion sizes, etc.)

☐Hunger and/or cravings

☐Eating triggers (e.g., emotions, stress, boredom, etc.)

☐Behavioral/schedule challenges (e.g., travel, work schedule, social calendar, etc.)

☐Medical condition(s) (e.g., diabetes, mood disorder, etc.)

☐Medication(s) (e.g., insulin, antidepressants, steroids, etc.)

☐Eating disorder (e.g., binge-eating disorder, bulimia, anorexia, etc.)

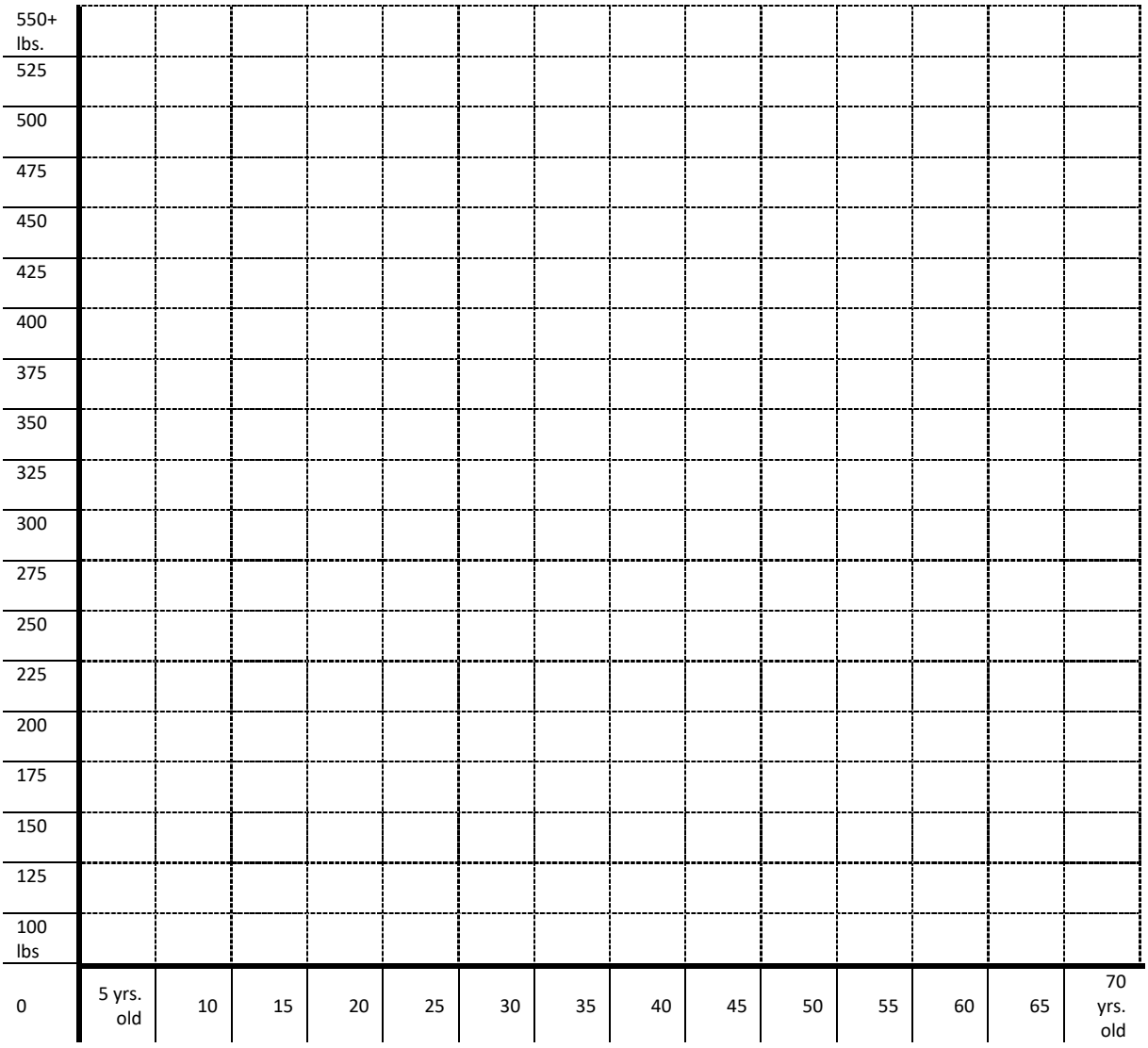
☐Other (specify): *(fill-in-blank)* _____

RELATIONSHIP(S):

Are you in a relationship ("partnered")?	☐Yes If so, does your partner have overweight and/or obesity? ☐yes ☐no		☐no	
Do you have children?	☐Yes If so, do any of your children have overweight and/or obesity? ☐yes ☐no		☐no	
Are the close individuals in your life supportive of weight efforts (in general)?	☐Yes	☐Neutral (neither supportive nor unsupportive)	☐no (we will talk in more detail)	☐Not close with anyone in particular

WEIGHT HISTORY

1. Weight Graph: Please **<u>place "dots"</u>** to chart your weight over the years (your best guess for ages that stand out in your memory – e.g.: *I was 200 lbs. at age 20, 300 lbs. at age 30; 250 at age 35*; etc.)



What was your:
Highest weight?
_____ lbs.

Lowest weight (as an adult)?
_____ lbs.

2. Weight "events": Please check any of the following <u>life events</u> that you think have contributed to your weight issues. (*Check all that apply*) ☐**NONE apply to me**

☐Illness/ disability	☐Trauma	☐ Psychological event(s)	☐Relationship change	☐Death of loved one(s)	☐Pregnancy
☐Other (specify):					

3. History of Eating Disorder(s):

☐I have NO history (past or present) of an eating disorder

☐I DO have a history of eating disorder(s): *(check all that apply)*

☐Anorexia ☐Bulimia ☐Binge-eating disorder

Details:

DIET HISTORY

1. Diet Habit Self-Assessment: Please check any of the following food categories that you have/had consumed on a regular basis AND have contributed to your weight issues. (*Check all that apply*):

☐**None of these apply to me**
☐Fast food and/or 'junk' food
☐Ultra-processed/packaged foods
☐Carbs (e.g., bread, rice, pasta; 'sweets')
☐Alcohol
☐Large Portions
☐Sweetened beverage(s) (e.g., fruit juice; soda-pop)
☐Eating out/ take out

2. Diet Patterns: Please check any of following eating behaviors that you notice yourself doing (on a regular basis). (*Check all that apply*)

☐Late night eating	☐Disinhibited eating (i.e.: lacking restraint)	☐"Grazing" (frequent snacking)
☐Infrequent eating (i.e.: eating only one meal a day)	☐Other (specify):	

3. Eating "Triggers": Please check any of the following items that trigger eating/ hunger/ cravings. (*check/ complete all that apply*)

☐Type(s) of Food	List: (*e.g.: chips)*	☐Family Issues
	_____	☐Work Issues
	_____	☐Illness
	_____	☐Stress
	_____	☐Emotions
	_____	☐Boredom
		☐Financial issues

4. Food restrictions and/or sensitivities: *Please check any/all that apply*.

☐NONE

☐Lactose intolerance	☐Allergy (specify):	☐Kidney/renal diet
☐Celiac disease	☐Warfarin restrictions	☐Soy

5. Current diet summary:

Number of Meals per day (average)	⇨					
Number of snacks per day (average)	⇨					
Snacking pattern	☐late night	☐ between meals	☐"Grazing" (throughout day)	☐no pattern	☒other	☐I do not snack
Average number of times you eat out per week (i.e., cafeteria, take-out, delivery, restaurant, fast food)					⇨	
Do you think your current diet is?	☐Well-balanced (including fruits, vegetables and protein) ☐Imbalanced					
Will the **~$14-16 per day** for the meal replacement be affordable?	☐YES	☐NO	☐I'm not sure			

Previous diet/ weight loss efforts:

1. "Formal" Weight programs tried: ☐Not applicable, I have never tried a formal diet program

Program (*e.g.: Weight Watchers*) LIST:	How much did you lose, initially? (Check applicable box)			Duration of participation (weeks, months, years) and in what year?	Duration of weight loss *(i.e.: For how long did you keep the weight off? – 3 months? 1 year?)*
	More than 10 lbs. lost (specify #)	5 – 10 lbs. lost	Less than 5 lbs. lost (or wt. gain)		
1.	☐ ____ lbs. lost	☐	☐		
2.	☐ ____ lbs. lost	☐	☐		
3.	☐ ____ lbs. lost	☐	☐		

2. Weight loss medications tried (click all that apply): ☐Not applicable, I have never tried meds for weight

☐phentermine (Adipex)	☐Orlistat (Alli, Xenical)	☐metformin (for weight)	☐Lorcaserin (Belviq)
☐Fen-Phen	☐Sibutramine (Meridia)	☐phentermine/ topiramate (Qsymia)	☐liraglutide (Saxenda)
☐bupropion/naltrexone (Contrave)		☐semaglutide (Wegovy)	☐Other

3. Have you ever had weight loss/ bariatric surgery?

☐No ☐Yes: ☐Roux-en-Y gastric bypass ☐sleeve gastrectomy ☐lap band ☐Other (specify):

University of Michigan Weight Management Program: HUM00030088		
Please **circle** the option that is the best explanation for why you chose medical management instead of surgery:		
1. I prefer to manage my weight by making changes to my lifestyle	2. Surgery has been considered but medical management is being pursued first	3. I have no interest in surgery given personal concerns about risk
4. Surgery is rejected due to friends'/family members' experience(s)	5. I was not a candidate for surgery based on my weight	6. I was not a candidate for surgery based on other mental/physical health condition(s)
7. Other (specify):		

Physical Activity History

1. **Historical trend:** Please use this visual analog scale to estimate the AVERAGE amount of physical activity/ exercise performed at various stages of life. Please review the scale/ interpretation and then write down a number that best fits your assessment. (e.g.: In young adulthood I was less active than before but still somewhat active and I estimate my activity level was a "60")

0 = no spontaneous activity/ exercise

100 = vigorous exercise/ activity on four or more days per week

Stage of life	Estimated AVERAGE activity level (Please record a number than falls between 0 – 100. See ruler/scale, above, for explanation)
Childhood	*(Example: 90)* _____
Teens	_____
Young adulthood (age 18-30)	_____
Adulthood (over age 30): ☐not applicable	_____

2. **Current exercise regimen**: ☐ Not applicable: I do not exercise, regularly. If not exercising, what are your barrier(s) to exercise (e.g.: time, injuries, etc.): _____

Type of exercise (*e.g.: walking*)	Number of times performed per week	Number of minutes per session (average)	Intensity of exercise (mild, moderate, rigorous)
1.			
2.			
3.			
4.			
5.			

MEDICAL CONDITION(S) Select **ANY/ALL** of the following medical conditions that you have (or had in the past)

☐**NONE – I have NEVER had ANY of these conditions**
☐Anemia
☐Acid reflux (aka: GERD)
☐Asthma
☐Blood clots (e.g., DVT, PE)
☐Cancer (: *(fill-in-type*_____
☐Coronary artery disease (aka: CAD)
☐Diabetes (**If selected, please complete the DIABETES form**)
☐Fatty Liver disease (aka: NASH, NAFLD)
☐Gallstones/ gallbladder disease
☐Gout
☐High blood pressure (aka: hypertension)
☐Other (specify): *(fill-in-blank)* _____

☐High cholesterol
☐Infertility
☐Low libido (sex drive)
☐Mood disorder (e.g., depression, anxiety, bipolar, etc.)
☐Obstructive sleep apnea (aka: OSA)
☐Osteoarthritis
☐Pain Syndrome
☐Peripheral vascular disease (e.g., stroke, PAD, etc.)
☐Polycystic Ovarian Syndrome (aka: PCOS)
☐Prediabetes
☐Snoring (if selected and you do NOT already have a diagnosis of sleep apnea, fill out the STOP-BANG form)
☐Urinary stress incontinence

_____

"STOP-BANG" questionnaire/score for obstructive sleep apnea screening

If you have never been tested for obstructive sleep apnea BUT have marked **"SNORING"** as an issue, please fill out this sleep apnea screening tool, below:

Do you snore loudly?	☐yes	☐no
Do you often feel tired, fatigued, or sleepy during the daytime?	☐yes	☐no
Has anyone observed you stop breathing during sleep?	☐yes	☐no
Do you have (or are you being treated for) high blood pressure?	☐yes	☐no

DIABETES ASSESSMENT FORM

☐I have/had **DIABETES (complete rest of form)**

☐I have pre-diabetes (i.e., borderline) (skip the rest of this page)

☐I do NOT have diabetes OR pre-diabetes (skip the rest of this page)

Have you heard of the "hemoglobin A1c" test?

☐NO

☐YES

If YES, what was YOUR last A1c test result (e.g., 7%? 10%? etc.)? _____ WHEN was it measured? _____

WHEN was diabetes diagnosed? (The year or approx. number of months/years ago) _____

What COMPLICATIONS of diabetes do you have? (Check all that apply)

☐**NONE (to my knowledge)**	☐Heart disease (coronary disease)	☐Kidney disease/ damage
☐Eye disease (retinopathy)	☐Peripheral vascular disease	☐Other: (specify)
☐Foot ulcers and/or amputations	☐Nerve damage (neuropathy)	

Which diabetes TREATMENTS are you **CURRENTLY** taking?

☐NONE – I am NOT taking any anti-diabetes medications

☐Pills (list) *[example – metformin, glipizide, actos, januvia; Jardiance]:*

_____

☐NON-insulin INJECTIONS (list) *[example – victoza, trulicity; ozempic]:*

_____

☐INSULIN (list) *[example – lantus, NPH, Humalog; U-500]:*

_____

Aside from these treatments, which diabetes TREATMENTS have you EVER taken (i.e., tried in the past)?

☐I have NOT tried any/other anti-diabetes medications

☐*[example – metformin, Invokana, byetta, regular insulin]:*

_____

Do you CHECK your blood sugars?

☐NO

☐YES, I use a CONTINUOUS GLUCOSE MONITOR

☐YES, I use a glucose meter (i.e., finger pokes)

If using a glucose meter, how OFTEN do you check your glucose/sugar levels *(i.e., 3x/day, a few times per week, etc.)*?

_____

Do you EVER have LOW BLOOD SUGAR episodes?

☐No, never

☐Yes

If YES, at what level of blood sugar do you feel low, what are your symptoms, and how OFTEN do they occur?

_____

MENSTRUAL/REPRODUCTIVE HISTORY

For WOMEN (Assigned Female at Birth):

Age of first menstrual period?	⇨

Menstrual status (check one)

☐**PRE**-MENOPAUSAL		☐**POST**-MENOPAUSAL			
What was the first day of your last menstrual period?	⇨ _____ Are periods regular? ☐ Yes ☐ No	Age of menopause (age of last period)?	⇨	Circumstances of menopause	☐Natural ☐Partial Hysterectomy (uterus removed; at least one ovary left) ☐Full Hysterectomy (uterus & BOTH ovaries removed) ☐Uterine ablation
IF **PRE-**menopausal, what is your birth control method?	☐Birth Control Pill ☐Depo-Provera ☐"Natural" family planning ☐Barrier methods (condoms, etc.) ☐abstinence ☐Intrauterine device (IUD – e.g.: Mirena) ☐Same-sex partner ☐Male partner vasectomy ☐other (specify): _____				

Have you ever been **pregnant?** ☐Yes ☐No (may skip the next section)

If "yes":

How many times have you been pregnant?			⇨	
How many children have you delivered?			⇨	
How many pregnancy losses have you had?			⇨	
What was the average amount of weight gained during your pregnancy/pregnancies?			⇨Miscarriage(s)(number): _____ ⇨Termination(s)(number): _____	
Did you ever have any complications during pregnancy?	☐Yes ☐No	If yes, did you have:	☐gestational diabetes ☐Pregnancy-induced high blood pressure	☐pre/eclampsia ☐other (specify):
Were there any fetal (baby) complications?	☐Yes ☐No	If yes, describe:	⇨	
What were the delivery methods for your pregnancy(cies)?	Vaginal (number of vaginal births): _____		c-section (number of c/s births): _____	