CLINICAL WEIGHT-LOSS WITH DR. RYAN HOFFMAN

Weight Loss & Medical History Questionnaire

PATIENT INFORMATION

FULL NAME: _____ DATE OF BIRTH: _____

PHONE #: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ALLERGIES: *Please list any food, drug, or medication hypersensitivities or allergies and reaction.*

_____

_____

MEDICATIONS: *Please list all medications you are currently taking, including medications you take 'as needed', vitamins and supplements, OTC medications, and any recreational drugs.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL HISTORY: *Check all that apply.*

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Diabetes
- ☐ Pre-Diabetes
- ☐ Infertility
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Headaches/ Migraines
- ☐ Glaucoma
- ☐ Angina
- ☐ Stroke
- ☐ Gout
- ☐ Arthritis
- ☐ Gallbladder Stones
- ☐ Indigestion/ Reflux
- ☐ Pancreatitis
- ☐ Sleep Apnea
- ☐ Thyroid Disorder
- ☐ Depression/ Anxiety
- ☐ Cancer _____

_____

Have you ever been diagnosed with an eating disorder? ☐ YES ☐ NO

SURGICAL HISTORY:

- ☐ Gastric Bypass
- ☐ Heart Bypass
- ☐ Gastric Banding
- ☐ Hysterectomy
- ☐ Gastric Sleeve
- ☐ Gallbladder
- ☐ Other _____
- ☐ Other _____

SOCIAL HISTORY:

- ☐ Current smoker
- ☐ Former smoker
- ☐ Non-smoker

Alcohol Consumption in the last year:

- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times/ month
- ☐ 4 or more times/week

Typical number of drinks per occasion:

- ☐ N/A
- ☐ 1 – 2
- ☐ 3 – 4
- ☐ 5 +

How often do you exercise?

☐ Never ☐ 1 – 2 times/ month ☐ 1 – 2 times/ week ☐ 3 -4 times/ week ☐ Everyday

How many hours do you sleep per night? _____

Do you feel rested in the morning? ☐ YES ☐ NO

WEIGHT HISTORY:

Current Weight: _____ Height: _____

Goal Weight: _____

I would like to achieve this goal in the following number of months: _____

Have you taken other medication to lose weight?

- ☐ Phentermine (Adipex)
- ☐ Phendimetrazine (Bontril)
- ☐ Wellbutrin
- ☐ Meridia
- ☐ Topamax
- ☐ Alli/ Xenical
- ☐ Belviq
- ☐ Saxenda
- ☐ Qsymia
- ☐ Contrave
- ☐ Ozempic/ Semaglutide
- ☐ Other: _____

Have you tried previous weight-loss programs?

- ☐ Weight Watchers
- ☐ OA
- ☐ South Beach
- ☐ HCG Diet
- ☐ Nutrisystem
- ☐ Jenny Craig
- ☐ Medifast
- ☐ Atkins
- ☐ Paleo
- ☐ Zone Diet
- ☐ Other: _____

What are your general health goals and improvements you wish to make?

_____

_____

Is there any additional information we should know?

_____

_____

Patient Name: _____