BRANCHES
Weight Loss • Wellness

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Sex: M / F

Referred by: _____

Preferred Pharmacy: _____Location: _____

Primary Care Provider: _____

Practice Name: _____ Date last seen: _____

Provider: _____ Specialty:_____

Practice Name: _____ Date last seen: _____

1. Are you allergic to any medications or food? □ Yes □ No. _____
2. Please list any medications, vitamins, or supplements you are currently taking (include dose):

_____ _____

_____ _____

_____ _____

_____ _____

3. Do you have a history of any of the following? (Please check all that apply)

□ High Blood Pressure	□ Anxiety	□ Thyroid cancer
□ High Cholesterol	□ Depression	□ Hypothyroidism
□ Heart Disease/Condition	□ Bipolar	□ Gout
□ Glaucoma	□ Substance Abuse	□ IBS
□ Sleep apnea	□ Seizures	□ PCOS
□ GERD	□ Migraines	□ Infertility
□ Low back pain	□ Knee pain	□ Other:_____

SURGICAL HISTORY

Please list any surgeries and when they occurred: _____

_____ _____

_____ _____

FAMILY HISTORY

	Age	Significant Medical History	Cause of Death	Obesity?
Father:	_____	_____	_____	Y / N
Mother:	_____	_____	_____	Y / N
Sibling:	_____	_____	_____	Y / N
Sibling:	_____	_____	_____	Y / N

OCCUPATION AND HOME LIFE

1. Marital status: □ Single □ Married □ Divorced □ Widowed
2. How many people live with you in your home? _____
3. If there are children in your home, please indicate their ages: _____
4. What is your occupation? _____
5. Do you have good social support for healthy lifestyle changes? □ Yes □ No

   If so, list your "support people":_____

WEIGHT HISTORY AND HEALTH BEHAVIORS

All questions contained in this questionnaire are optional and will be kept strictly confidential.

WEIGHT HISTORY

1. At what age did weight become a problem for you?

   □ Childhood □ Teens □ Adulthood □ Pregnancy □ Menopause

2. Have there been any circumstances or life events that have triggered weight gain for you?

   □ Pregnancy □ Job change □ New medication □ Stress □ Boredom

   □ Other_____

3. What was your weight one year ago? _____ Two years ago? _____ Five years ago? _____
4. What has been your highest weight? _____
5. What was your weight around age 20? _____
6. Have you lost weight in the past? If so, select from the list the program/method, and how much weight you lost. (Check all that apply):

   □ Weight Watchers □ Nutrisystem □ Jenny Craig
   □ LA Weight Loss □ Atkins □ South Beach
   □ Zone diet □ Medifast □ Dash diet
   □ Paleo diet □ HCG diet □ Mediterranean diet
   □ Ornish diet □ Other: _____

7. Have you ever used any prescription medications for weight loss? (check all that apply):

   □ Phentermine (Adipex) □ Meridia □ Xenecal/Alli □ Phen/Fen
   □ Phendimetrazine (Bontril) □ Topamax □ Saxenda □ Diethylpropion
   □ Bupropion (Wellbutrin) □ Belviq □ Qsymia □ Contrave
   □ Other (including supplements) _____
   □ 7a. If so, how much weight did you lose with the medication, and did you experience any side effects? _____

8. Have you ever had bariatric surgery? □ Yes □ No.

If yes, bariatric procedure: _____ Date: _____

Highest weight: _____ Lowest weight: _____

Surgeon and location: _____

Any complications? _____

10. What do you consider some of your barriers when it comes to managing your weight?

□ Hunger □ Cravings □ Fatigue □ Finances

□ Time □ Knowledge □ Other_____

11. What are your goals/anticipated outcomes from this program? _____

_____

NUTRITION

1. How do you feel about your current eating habits?

□ Could be better □ Pretty good overall but room for improvement □ I have great habits

2. Are you currently following a particular eating plan? □ Yes □ No.

If yes, which one?_____

3. Have you tried particular eating plans or diets in the past? □ Yes □ No

If yes, which ones have you tried, and which ones worked well or did not work for you?

_____

4. Number of meals and snacks you eat on an average day:

□ 1-2 □ 3 □ 3-5 □ 6-8 □ 8-10+

5. Food allergies / intolerances: _____

6. Who does most of the cooking and/or grocery shopping at your house?

□ Self □ Spouse/Partner □ Other member of household □ Other

7. Food preferences including ethical or cultural considerations: _____

_____

8. How many times per week do you eat food or drink beverages from a restaurant?

□ Never □ 1-3x/week □ 4-6x/week □ More than 7x/week

9. Triggers for eating (click all that apply:)

□ Hunger □ Stress □ Boredom □ Cravings

□ Time of day □ Other _____

10. Barriers to eating healthy (click all that apply):

□ Cooking skills □ Time □ Financial reasons □ Access to healthy foods

□ Schedule □ Home/work circumstances

11. During the last 3 months, did you have any episodes of excessive overeating? □ Yes □ No.

If yes, do you feel distressed about your episodes? □ Yes □ No

12. Current or past history of an eating disorder? □ Yes □ No.

If yes, please elaborate: _____

_____

ALCOHOL/TOBACCO

1. Do you drink alcohol? □ Yes □ No. If yes, what kind? (Click all that apply)

□ Beer □ Wine □ Liquor □ Cocktails

2. How many drinks per week do you drink?

□ None □ 1-3 □ 4-7 □ more than 8

3. Are you concerned about the amount you drink? □ Yes □ No

4. Tobacco status: □ Nonsmoker □ Ex-smoker □ Current smoker □ Vape user

5. Do you participate in recreational drug use? □ Yes □ No

CALORIC BEVERAGES

1. Do you drink caloric beverages such as soda, juice, sweetened tea, or coffee with creamer?

□ Yes □ No. If yes, what kind? _____

If yes, what kind(s)?_____

How many ounces per day on average?_____

PHYSICAL ACTIVITY

1. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class?

□ Never □ 1-2x/ week □ 3-4x/ week □ 5 or more x/week

2. How many minutes does each bout of exercise typically last?

□ 10 min or less □ 10 min - 20 min □ 20 min - 30 min □ more than 30 min

3. Type of activities you participate in regularly (click all that apply).

□ Walking □ Biking □ Strength training □ Yoga

□ Other _____

4. List any barriers to physical activity. (Time, joint pain, motivation, etc.)

_____

5. List equipment / spaces available to you for activity.

□ Gym membership □ stationary bike □ free weights □ walking path

□ Other _____

6. What types of activities do you enjoy or have enjoyed in the past? _____

SLEEP

1. How many hours of sleep do you average per night?

□ Less than 5 □ 6-8 hours □ 9 or more hours

2.Do you work a night shift or shift work? □ Yes □ No

3. Usual bedtime:_____Usual waking time: _____

4. Do you have trouble falling asleep or staying asleep? □ Yes □ No

5. Have you ever been evaluated for sleep apnea or other sleep related disorders? □ Yes □ No.

If yes, were you diagnosed with sleep apnea? □ Yes □ No

If yes, do you use a CPAP, BiPap or other device? _____

6. Do you snore? □ Yes □ No

7. Are you tired throughout the day? □ Yes □ No

8. Has anyone observed that you stop breathing during sleep? □ Yes □ No

9. Do you often wake up with headaches in the morning? □ Yes □ No

10. Do you take naps during the day? □ Yes □ No

MENTAL HEALTH

1. Is stress a major problem for you? □ Yes □ No

Rate your stress level on a scale from 1 to 10: _____

2. Do you feel like you have healthy coping mechanisms for stress? □ Yes □ No

How do you cope with your stress? _____

3. Do you consider yourself an “emotional eater”? □ Yes □ No

4. Do you ever feel depressed? □ Yes □ No

5. Have you ever been diagnosed with a mental health condition? □ Yes □ No

If yes, which mental health condition? □ Anxiety □ Depression □ Bipolar disorder

Other _____

6. Do you cry frequently? □ Yes □ No

7. Have you ever attempted suicide? □ Yes □ No

8. Have you ever seriously thought about hurting yourself? □ Yes □ No

9. Have you ever been to a counselor or other mental health professional? □ Yes □ No

If yes, are you currently receiving counseling? □ Yes □ No

WOMEN ONLY

1. Age at onset of menstruation: _____

2. Date of last menstruation: _____ Date of Hysterectomy: _____

3. Do you have any of the following: heavy periods, irregularity, spotting, pain or discharge?

□ Yes □ No

4. Number of pregnancies_____Number of live births _____

5. Are you pregnant or breastfeeding? □ Yes □ No

6. Are you planning a pregnancy within the next year? □ Yes □ No

7. Do you have any problems with urinary or bladder control? □ Yes □ No

8. Have you ever been diagnosed with PCOS? □ Yes □ No

9. Have you been affected by infertility? □ Yes □ No

10. Date of last pap: _____

MEN ONLY

1. Do you usually get up to urinate during the night? □ Yes □ No

If yes, number of times: _____

2. Have you ever been tested for low testosterone? □ Yes □ No

3. Have you ever been treated for low testosterone? □ Yes □ No

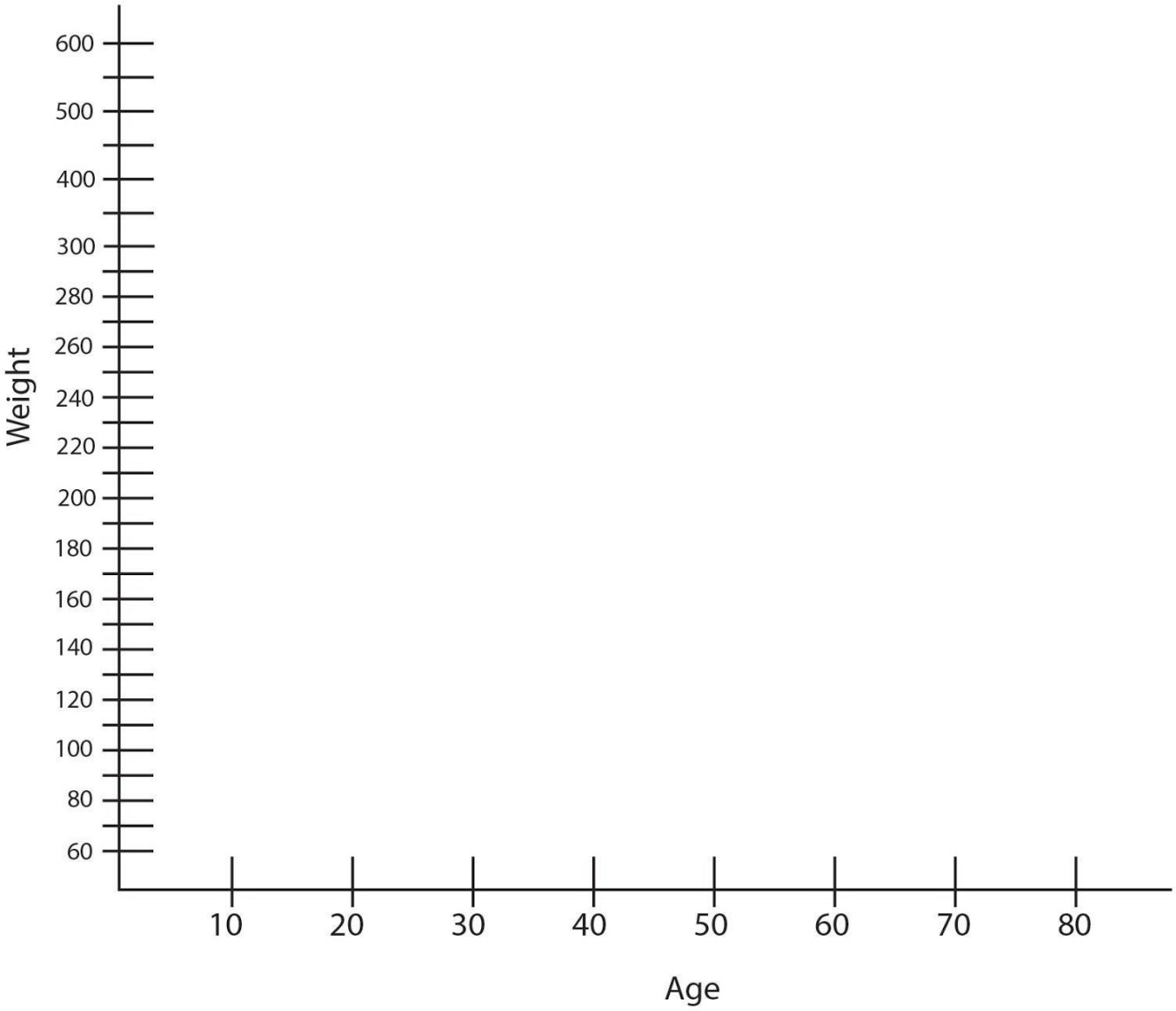
24 HOUR FOOD LOG

Please list your food and beverage intake for the past 24 hours.

TIME	FOOD & BEVERAGES CONSUMED	PLACE CONSUMED

WEIGHT GRAPH

Please chart your age and weight on the chart below.



Review of Systems (Please check all symptoms you have experienced in the last week)

General	___ fatigue ___ daytime sleepiness	___ recent weight change	___ trouble sleeping
HEENT	___ blurry vision	___snoring	
Cardiovascular	___chest pain/tightness	___palpitations	__irregular heart beat
	___ waking gasping for air		
Pulmonary	___shortness of breath at rest	___ shortness of breath with activity	___ sleep apnea
GI	___abdominal pain	___ GERD/heartburn	___ constipation
	___ diarrhea	___ IBS mixed	___ nausea
GU	___ kidney stones ___ frequent urination	___ urinary difficulties	___ reduced libido
Extremities	___ back pain ___ gout	___ joint pain	___leg swelling
Endocrine	___ excessive thirst ___ cold intolerance	___ excessive urination ___ female hair loss	___ fatigue
Neurological	___headache	___tingling of hands or feet	
Psychiatric:	___ depression	___ anxiety	___ bipolar
Skin	___ unwanted facial hair	___acne	___rash
Female Reproductive	___headaches ___ PMS	___ cramps ___excessive bleeding	___ mood swings ___ appetite changes

*On a scale from 1-10 with 10 being the **MOST** committed, how committed are you to taking action and making a change in your life today?*

1 2 3 4 5 6 7 8 9 10

Thank you for choosing Branches Weight Loss and Wellness!