Island Health Weight & Wellness History Form

Name ________ Date ________ Birth Date ________

Medications & Allergies	**Yes**	**No**
Are you currently taking medication, including over-the-counter or herbal medication? Please list and include dosage:	☐	☐
Do you take vitamin supplements? Please list:	☐	☐
Do you have any allergies? Please list, including drug allergies:	☐	☐

History of Present Illness		
What was your highest adult weight?		
What was your lowest adult weight?		
At what age did you achieve your lowest adult weight?		
Have you ever attempted to seriously lose weight? If yes, what did you try?	☐	☐
Do you exercise regularly? If yes please explain the activities, frequency, and duration:	☐	☐
Are you aware of any problems that would be aggravated by exercise? If yes, please explain:	☐	☐
Please rate your **confidence** that you will reach your long-term weight and fitness goals on a scale of 1-10 where one is not confident at all and ten is extremely confident: 1 2 3 4 5 6 7 8 9 10		
Please rate your **motivation** to reach your long-term weight and fitness goals on a scale of 1-10 where one is not motivated at all and ten is extremely motivated: 1 2 3 4 5 6 7 8 9 10		
What has motivated you to lose weight at this time? Please be as specific as possible:		
Do you have specific personal goals related to your weight, exercise or lifestyle? If yes, please explain:	☐	☐

Binge Eating Screening	**Yes**	**No**
Do you often feel that you can't control what or how much you eat?	☐	☐
Do you often eat within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
Has this been as often, on average, as twice a week for the last 3 months?	☐	☐
Do you often eat more rapidly than normal?	☐	☐
Do you often eat until feeling uncomfortably full?	☐	☐
Do you often eat large amounts of food when not feeling physically hungry?	☐	☐
Do you often eat alone because of embarrassment by the amount of food consumed?	☐	☐
Do you often feel disgusted with yourself, depressed, or guilty after overeating?	☐	☐
How many times per week do you have episodes of binge eating?		

Bulimia Screening	**Yes**	**No**
In the last 3 months have you often done any of the following in order to avoid gaining weight?		
Made yourself vomit?	☐	☐
Took more than twice the recommended dose of laxatives?	☐	☐
Fasted - not eaten anything at all for at least 24 hours?	☐	☐
Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐
If you checked "Yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

Past Medical History	**Yes**	**No**
Have you ever been diagnosed with any of the following health problems? ***Please explain any 'yes' answers.***		
Diabetes	☐	☐
Metabolic Syndrome, Pre-Diabetes, Impaired Fasting Glucose or Insulin Resistance	☐	☐
Thyroid disease (Hypothyroid, Hyperthyroid, Graves disease, Thyroiditis, Nodule or Goiter)	☐	☐
Cancer	☐	☐
Heart problems (irregular heartbeat, heart disease)	☐	☐
Ever examined by a cardiologist?	☐	☐
Stroke/Transient Ischemic Attacks (TIA)	☐	☐
High Blood Pressure	☐	☐
Elevated Cholesterol or Triglycerides	☐	☐
Asthma or COPD (Chronic Obstructive Pulmonary Disease)	☐	☐
Kidney Stones	☐	☐
Gallstones or other gallbladder disease	☐	☐
Frequent Heartburn	☐	☐
GERD (Gastro-Esophageal Reflux Disease) or Esophagitis	☐	☐
Stomach Ulcers	☐	☐
Chronic Diarrhea	☐	☐
Chronic Constipation	☐	☐
Lactose Intolerance	☐	☐
Crohn's disease or Ulcerative Colitis	☐	☐
Irritable Bowel Syndrome (IBS)	☐	☐
Celiac disease	☐	☐
Migraines or severe or chronic headaches	☐	☐
Fainting spells, Dizziness, or Vertigo	☐	☐
Anemia	☐	☐
Arthritis in a weight-bearing joint (foot, ankle, knee, hip, back)	☐	☐
Gout	☐	☐
Glaucoma	☐	☐
Insomnia	☐	☐
Sleep Apnea	☐	☐
Seizure disorder or history of convulsions	☐	☐
Depression	☐	☐

Past Medical History Continued

	Yes	No
An Eating Disorder	☐	☐
Severe Anxiety, Panic Attacks, or Bipolar Disorder	☐	☐
Have you ever tried to intentionally hurt yourself?	☐	☐
Do you have unpredictable mood swings?	☐	☐
Are you currently undergoing counseling?	☐	☐
Have you ever had any surgeries? Please list:	☐	☐
Do you have any other health concerns that have not been listed above? Please explain:	☐	☐
If female:		
Are you currently pregnant?	☐	☐
Are you currently breast feeding?	☐	☐
Have you ever been diagnosed with PCOS? (Polycystic Ovary Syndrome)	☐	☐
Are your periods regular?	☐	☐
Please estimate the date of your last menstrual period:		
How many pregnancies?		
How many miscarriages?		

Sleep Apnea Screening

	Yes	No
Do you snore loudly?	☐	☐
Do you often feel tired or sleepy during the daytime?	☐	☐
Has anyone ever observed you stop breathing, choking or gasping during your sleep?	☐	☐
Do you often wake up in the morning with a headache?	☐	☐
Do you often awaken during the night?	☐	☐
Do you have problems with lack of concentration during the daytime?	☐	☐

Depression Screening

Yes No

Over the last two weeks have you been bothered by the following problems? Please rate your answers using this scale:
0= not at all, 1 = several days, 2 = more than half of the days, 3 = nearly every day.

Little interest or pleasure in doing the things you normally enjoy?	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3

Social History

	Yes	No
Do you participate in any alternative medicine therapies? (Such as Acupuncture, Chiropractic, Homeopathy) Please list:	☐	☐
Do you use tobacco products or have you used them in the past?	☐	☐
What year did you begin smoking?		
What year did you quit smoking?		
How much per day?		
Chewing tobacco?		

Social History Continued	Yes	No
Do you drink alcohol? If yes, how many drinks in a typical week?	☐	☐
Do you drink caffeinated beverages? If yes, how much per day?	☐	☐
Have you ever used recreational drugs? If yes, please explain:	☐	☐
Have you ever had issues with drug abuse or chemical dependency? If yes, please explain:	☐	☐
Do you have a living will?	☐	☐

Family History	Yes	No
Do you have a family history of any of the following? ***If yes, please indicate who in your family.***		
If you do not know any of your family history, please check here: ☐		
Stroke Family member(s):	☐	☐
Diabetes Family member(s):	☐	☐
High Blood Pressure Family member(s):	☐	☐
Heart disease Family member(s):	☐	☐
High Cholesterol Family member(s):	☐	☐
Thyroid disease Family member(s):	☐	☐
Cancer Family member(s): Type:	☐	☐
Any other relevant family history you think we should know about? If so, what?	☐	☐

Patient Signature **Date**

EMR Input By **Date**

Health Care Provider Review **Date**