Name: **WM New Patient Intake Form**

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1. **Do you have any of the following? (Please check all that apply to you)**
   - ☐ Diabetes
   - ☐ Pre-Diabetes
   - ☐ High Blood Pressure
   - ☐ Hypothyroidism
   - ☐ Heart Disease/Stroke
   - ☐ Cholesterol Problems
   - ☐ Obstructive Sleep Apnea
   - ☐ Non-alcoholic Fatty Liver Disease
   - ☐ Acid Reflux/Heartburn
   - ☐ Osteoarthritis
   - ☐ Polycystic Ovarian Disease
   - ☐ Gallbladder Disease
   - ☐ Blood Clots

2. **Approximately how many pounds have you gained? _____lbs Over the past _____months/years.**

3. **Have you tried weight loss programs?** ☐ **Yes** ☐ **No (If yes, please check all that apply to you)**
   - ☐ Atkins Diet ☐ South Beach ☐ Weight Watchers ☐ Jenny Craig
   - ☐ Bariatric Surgery ☐ Nutrisystem ☐ Self directed diet and exercise program
   - ☐ Physician directed medical weight management plan with: ☐ Phentermine ☐ HCG

4. **How many pounds would you like to lose? _____lbs**

5. **What is your final weight loss goal? _____lbs**

6. **Do you have a clothing size goal?** ☐ **Yes** ☐ **No** **If yes, what is your goal size? _____**

7. **Do you exercise?** ☐ **Yes, What & How Often? _____**
   ☐ **No**

8. **What do your meals consist of? (Please check all that apply to you)**

   Breakfast:
   - ☐ Cereal ☐ Fast Food ☐ Eggs ☐ Protein Bar ☐ Protein Shake
   - ☐ Nothing ☐ Other: _____

   Lunch:
   - ☐ Fast Food ☐ Sandwich ☐ Salad ☐ Other: _____

   Dinner: _____

   Snacks: _____

9. **Approximately how much of the following fluids do you drink daily?**
   - _____ Cups of Water _____ Regular Sodas _____ Sweet Tea
   - _____ Coffee (Regular/Decaf) _____ Diet Sodas _____ Unsweetened Tea

10. **Do you drink alcohol?**
    - ☐ Yes **If yes, how often?** ☐ Daily ☐ Social Only
    - ☐ No

11. **Your bowel movements are:**
    - ☐ Normal ☐ Irregular with loose stools ☐ Irregular with constipation

12. **Your sleep patterns are described as:**
    - ☐ Good ☐ Occasional Insomnia ☐ Insomnia

13. **How many hours per night do you sleep? _____ Hrs**

14. **Do you experience any of the following symptoms:**
    - ☐ Fatigue ☐ Short of Breath ☐ Joint Pain (Hips, Knees, Ankles)

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15. Do you snore? □ **Yes** □ **No**

16. Do you smoke? □ **Yes, What & how much daily?** _____
□ **No**

17. Do you have a FAMILY HISTORY of: (Please check all that apply to you)
□ **Diabetes** □ **Heart Disease** □ **High Cholesterol** □ **High Blood Pressure**

18. Have you had blood work done outside our office recently? □ **Yes** □ **No**

19. How did you hear about Piedmont Healthcare Weight Management? _____

20. Who is your primary care doctor? _____

21. What is your current occupation? _____

22. Please list all previous surgeries: _____
_____
_____
_____
_____

23. Please list all current medications: _____
_____
_____
_____
_____