CENTRA

Centra Weight Loss Clinic
Initial Appointment Questionnaire

***Please note: To provide appropriate care forms MUST be complete prior to your initial visit.**

Name	Date of Birth
Physical Address/Phone #	Email

Physician Information		
Primary Care Provider (Name):	Location (City, State):	Date of last visit:
Referring Provider (Name):		
Have you had lab tests in the last 3 months? Yes No (If yes, please bring them to your initial visit or notify us so we may request these results.)		

Pharmacy Information	Preferred Pharmacy (Name):
Location (city, street):	Mail Order Pharmacy? Y N Name:
Pharmacy Benefits ID# (Often on separate card, different from insurance ID#):	

Insurance Information	Policyholder Name (if other than patient)
Primary Insurance (i.e. BC/BS, Aetna, etc.)	Primary Insurance Phone #
ID / Policy Number	Group Number
Secondary Insurance Policyholder Name (if other than patient)	
Secondary Insurance (if applicable)	Secondary Insurance Phone #
ID / Policy Number	Group Number

The information provided is correct to the best of my knowledge. My signature below authorizes CENTRA to communicate with me via email, phone, or other means indicated.

Signature*: _____ **Date:** _____

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Personal (YOUR) Medical History (check all that apply)

CONDITION	√	Comments	CONDITION	√
Asthma			Hypertension (high blood	
Cancer			Hypothyroidism (low thyroid)	
Thyroid			Infertility	
Liver			Irregular heartbeat	
Other – Specify:			Irregular Menstrual Cycle	
COPD/Emphysema			Kidney Disease	
Heart Attack, Angina		□ Age at first symptoms	Liver Disease (fatty liver,	
Congestive Heart Failure (CHF)		□ Using CPAP or BiPAP	Obstructive Sleep Apnea	
Depression			Pancreatitis	
Diabetes Mellitus (type 1 or 2)		□ On Insulin	PCOS (Polycystic Ovaries)	
Food Allergies			Pregnant/Breastfeeding	
GERD (acid reflux)			Seizure Disorder	
Glaucoma			Stroke	
Hyperlipidemia (high cholesterol)			Suicidality (current)	

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Surgical History	You may not be familiar with some terms but mark all that apply. Add anything not listed.	
SURGERY TYPE	**APPROACH**	**YEAR**
☐Appendix (appendectomy)	□ Laparoscopic □ Open □ I don't know	
☐Gallbladder (cholecystectomy)	□ Laparoscopic □ Open □ I don't know	
☐Hysterectomy	□ Laparoscopic □ I don't know □ Open □ Vaginal	
☐Previous bariatric surgery *List type:*	□ Laparoscopic □ Open	*Hospital:*
☐Other *List type:*		
☐Other *List type:*		

Preventive Care	Date last done	Result
Colonoscopy		

Family Medical History	☐ Check here if adopted/unknown				
CONDITION	**Mother**	**Father**	**Sibling(s)**	**Grandparent**	**Comments**
Cancer	√	√	√	√	
Colon					
Breast					
Thyroid					
Other – Specify:					
Coronary Disease (Heart Attack, Angina)					Age at onset:
Congestive Heart Failure (CHF)					
Depression					
Diabetes Mellitus (type 1 or 2)					
Liver Disease					
Overweight/Obesity					
Stroke					

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Mammogram (females only)		

Medications	**List all current medications or attach up-to-date and current list (attached list if necessary). **Please include ALL OTC supplements!* (attach list if needed)**		
MEDICATION	**DOSE**	**SCHEDULE**	**PURPOSE**
Example only: *Metformin*	*500mg*	*1 pill twice a day*	*diabetes*

Allergies	**List all medication/food allergies or indicate: ☐ *I have no known allergies.***
MEDICATION/TYPE OF REACTION	**MEDICATION/TYPE OF REACTION**

Social History	**Please answer ALL questions to the best of your knowledge.**			
TOBACCO USE	**Do you smoke? YES - NO**	**Did you ever used to smoke? YES - NO I quit in _____ *(yr)***	**Packs/day: _____ Years: _____**	**Willing to quit? YES - NO**
ALCOHOL USE	**Do you drink? YES - NO**	**_____ drinks per week of (*circle*) beer / wine / liquor**		
SUBSTANCE USE	**Do you or have you use(d) any illicit drugs: YES – NO If Yes, which ones: ☐ Marijuana ☐ Ecstasy ☐ Heroin ☐ Meth(amphetamines) ☐ Cocaine ☐ Other:_____**			

Review of Body Systems	**Mark *all symptoms* that you are *****currently***** **experiencing *NOW***

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GENERAL	□Fevers or chills □Bingeing □Purging □Loss of appetite □Excessive sweating	**URINARY**	□Pain with urination □Kidney stones □Trouble starting stream □ Trouble stopping stream
EYES	□Burning □Irritation □Change in vision □Double vision	**SKIN / BREAST**	□Dark, velvety patches □NEW breast lump
EARS / NOSE / THROAT	□Nasal congestion □Cough □Nosebleeds	**HEMATOLOGIC**	□Easy bruising □Prolonged bleeding □Swollen glands
RESPIRATORY	□Wheezing □Pneumonia □Shortness of breath	**MUSCULOSKELETAL**	□Back Pain □Joint Pain: _____ □Tendon nodules (esp. Achilles) □Muscle aches
CARDIOVASCULAR	□Chest pain □Chest pressure □Palpitations / irregular heartbeats	**NEUROLOGICAL**	□Numbness □Tingling □Seizures □Headaches □Dizziness
GASTROINTESTINAL	□Nausea □Vomiting □Constipation □Acid reflux □Diarrhea □Abdominal pain	**SLEEP**	□Loud Snoring □Daytime Fatigue □Insomnia

The entire weight management history must be filled out, to the best of your knowledge. Do not write "All my life" or "Years" but be specific, as close as you can recall.

Weight Management History	**LENGTH OF TIME (MONTHS)**	**YEAR**	**WEIGHT LOST (lbs)**	**WEIGHT RE-GAINED (lbs)**
Example: ***Low calorie diet***	*10 months*	*2002*	*30 lbs.*	*15 lbs.*
Low calorie diet				
Low fat diet				
Atkins diet				
Optifast® / Medifast®				
Phentermine				
Other prescription meds *(Name:_____)*				

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Diet shots (B12, etc.) *(Name:_____)*				
Non-prescription diet pills *(Name:_____)*				
Doctor-supervised diet				
Registered Dietician (RD)				
Exercise program				
Nutrisystem®				
T.O.P.S.®				
Weight Watchers®				
Jenny Craig®				
Ketogenic Diet:				
Other:				

Obesity History	**1. Highest weight (lbs)? Age?**	**2. Lowest adult weight? Age?**
3. At what age did you FIRST consider yourself to be overweight?		**4. What do you think is the reason for your weight gain?**
5. Family History of Overweight/Obesity? YES NO If yes, who?		**6. How does your weight currently limit you?**
7. What do you see as your 2 biggest barriers to losing weight?		
8. What are at least 2 benefits of weight loss for you?		
9. Would you like to join our Facebook Support Group? No thanks/"Sign me up" Email: _____		
Answer the next 2 questions on a scale of 1-10 (1 = none or least likely; 10 = Strong or most likely)		
10. What is your current level of *DESIRE* to get to a healthier weight?		**11. Where would you currently rate your *LIKELIHOOD* of success?**

Physical Activity	**1. Do you have any limitations or injuries that make exercise difficult? Explain.**
2. Do you engage in any regular exercise now? What kind? How much? If not, why?	

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3. Have you enjoyed exercise in the past? Why or why not?
4. Have you ever stuck to a consistent exercise plan in the past? Why or why not?
5. How would you rate your current energy level (1 = very low; 10 = very high)?

Sleep Assessment	
1. Do you snore loudly?	**☐ Yes ☐No**
2. Do you often feel tired, fatigued, or sleepy during the daytime?	**☐ Yes ☐No**
3. Has anyone observed you stop breathing during sleep?	**☐ Yes ☐No**
4. Do you have (or are you being treated for) high blood pressure?	**☐ Yes ☐No**

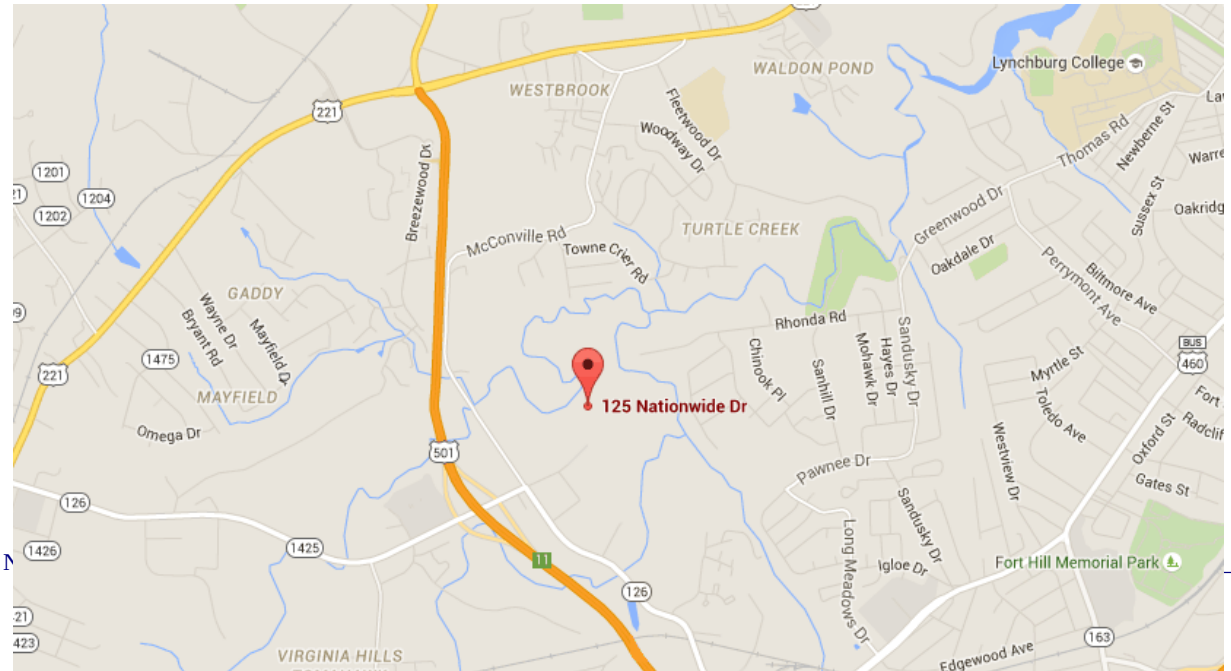
Upon completion, submit this information packet either *in person* or *by mail* to:

Centra Weight Loss Clinic (Administration)
125 Nationwide Drive
Lynchburg, VA 24501

We want to safeguard your personal information as best we can. Please do not email or fax this packet. We will contact you after receiving your packet.

Clinic appointments will be held at:

Centra Weight Loss Clinic
125 Nationwide Drive
Lynchburg, VA 24502



You may keep this sheet as a reference.

NAME: _____ DATE: ____/_____/_____ DATE OF BIRTH: _____/_____/_____