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

Physician Information	Referring Physician / PCP (Name)	
Location (city, state)	Date of last visit	Date of next visit
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
Location (city, state)	Phone number

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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Medical History	You may not be familiar with some terms but mark all that apply.		
CONDITION	**MANAGEMENT** (Check all that apply)	**CONDITION**	**MANAGEMENT** (Check all that apply)
☐Type 2 Diabetes	□ Diet controlled □ Oral Medication □ Insulin	☐Congestive Heart Failure (CHF)	□ Medication □ Hospitalization □ Cardiologist: _____
☐Hypertension (High Blood Pressure)	□ Diet controlled □ Medication Usual reading: _____ /	☐Coronary Disease (Heart Attack, Angina)	□ Medication □ Stents: _____ □ Bypass surgery
☐High cholesterol (Hyperlipidemia)	□ Diet controlled □ Medication	☐Liver Disease *(List type: _____)*	
☐Obstructive Sleep Apnea	□ Using CPAP □ CPAP prescribed, not used □ Using mouth spacer	☐Kidney Disease	□ Medication □ Dialysis □ Nephrologist: _____
☐Gastroesophageal Reflux (GERD, heartburn)	□ Diet controlled □ Medication	☐Venous Insufficiency	□ Swelling □ Compression hose □ Ulcers
☐Arthritis / Joint Pain	□ Physical therapy □ Prior surgery	☐COPD (Emphysema or Chronic Bronchitis)	□ Medication □ Oxygen
☐Back Pain	□ Chiropractor / PT □ Medication □ Other:	☐Asthma	□ Medication □ Frequency of inhaler use: _____
☐Depression	□Therapy / counseling □ Medication	☐Gallstones	
☐Infertility / Polycystic Ovaries		☐Blood Clots in Leg / Lung (DVT/PE)	□ Blood thinner – current □ Blood thinner – past □ IVC filter
☐Irregular Menstrual Cycles		☐Cancer *(Type: _____)*	□ Currently under treatment
☐Stress Urinary Incontinence (leakage)	□ Using pads □ Medication Leakage frequency:	☐Suicidality	□ Currently □ Only in past
☐Thyroid disease	□ Medication □ Prior thyroid surgery	☐Pancreatitis	□ Once □ Recurrent □ Cause? _____
☐Thyroid Cancer	□ Currently under treatment □ Medication □ Prior thyroid surgery	☐Pregnancy/Breastfeeding	□ Currently □ Desire pregnancy □ Currently breastfeeding
☐Glaucoma	□ Open-Angle □ Closed-Angle □ Medication	☐Other:	

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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:*		
☐Other *List type:*		

Medications	List all current medications or attach up-to-date and current list.		
MEDICATION	**DOSE**	**SCHEDULE**	**PURPOSE**
Example only: *Metformin*	*500mg*	*1 pill twice a day*	*diabetes*

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

MEDICATION NAME	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:_____			
EMPLOYEMENT	□ Full-time □ Part-time □ Student □ Unemployed □ Disability □ Other:_____			

Review of Body Systems	Mark *all symptoms* that you are *****currently***** experiencing.		
GENERAL	□ Fevers or chills □ Loss of appetite □ Excessive sweating	URINARY	□Pain with urination □Kidney stones □Trouble starting/stopping stream
EYES	□ Burning / irritation □ Change in vision □ Double vision	SKIN / BREAST	□ Skin lesion (new) □ Rash □ Changing mole □Breast lump (new)
EARS / NOSE / THROAT	□ Earaches □Nasal congestion □ Ringing in ears □Cough □ Nosebleeds □Sore	HEMATOLOGIC	□Easy bruising □Prolonged bleeding □Swollen glands
RESPIRATORY	□Wheezing □Pneumonia □Shortness of breath □ Asthma	MUSCULOSKELETAL	□Back or neck pain □Painful joints: _____ □Muscle aches
CARDIOVASCULAR	□Chest pain □Chest pressure □Palpitations / irregular heartbeats	NEUROLOGICAL	□Numbness or tingling □Seizures □Headaches □Dizziness / vertigo
GASTROINTESTINAL	□Nausea / vomiting □Constipation □ Acid reflux □Diarrhea (heartburn/GERD) □Abdominal pain	SLEEP	□Snoring loudly (according to partner) □Fatigue during daytime / nodding off

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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®				
Phen-Fen				
Other prescription meds *(Name:_____)*				
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®				
Other:				
Other:				

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Obesity History		
	1. Highest weight (lbs)? 2. Age?	3. Lowest adult weight? 4. Age?
4. At what age did you FIRST consider yourself to be overweight?		5. What do you think is the reason for your weight gain?
6. Family History of Overweight/Obesity? YES or NO If yes, who?		7. How does your weight currently limit you?
8. What do you see as your 2 biggest barriers to losing weight? 1.	2.	
9. What are at least 2 benefits of weight loss for you? 1.	2.	
Answer the next 3 questions on a scale of 1-10 (1 = none or least likely; 10 = Strong or most likely) 10. How would you rate your current energy level?		
11. What is your current level of DESIRE to get to a healthier weight?		12. Where would you currently rate your LIKELIHOOD of success?

Sleep Assessment	
	1. How much sleep do you get at night, on average?
2. Do you feel rested when you wake up in the morning?	
3. Has anyone told you that you stop breathing during your sleep?	
4. How likely are you to fall asleep or doze in the following situations (NOT just feeling tired)? Use the scale below to choose the most appropriate number for each situation: 0 – No chance of dozing 1 – Slight chance of dozing 2 – Moderate chance of dozing 3 – High chance of dozing	

SITUATION	CHANCE OF DOZING	SITUATION	CHANCE OF DOZING
Sitting and reading		Lying down to rest in the afternoon (when able)	
Watching TV		Sitting and talking to someone	
Sitting inactive in a public place (theater or meeting)		Sitting quietly after lunch without alcohol	
As a passenger in a car for 1 hour without a break		In a car, while stopped for a few minutes in traffic	

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? If not, why?	
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?	

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Possible Weight Management Options
1.. If recommended, how willing are you to consider the use of medication as part of your obesity treatment? (Please only circle one number) Not a chance 0 1 2 3 4 5 6 7 8 9 10 Very Likely
2. If recommended, how willing are you to consider the use surgical options as part of your obesity treatment? (Please only circle one number) Not a chance 0 1 2 3 4 5 6 7 8 9 10 Very Likely
3. Do you often feel like you must eat more than is "normal" before you want to stop eating? (Please only circle one) Always Sometimes Rarely Never
4. Do you often feel like your "fullness" after eating does not last as long as it should? (Please only circle one) Always Sometimes Rarely Never
5. Do you feel that you often eat for comfort or to cope with positive or negative emotions? (even if you are not hungry)? (Please only circle one) Always Sometimes Rarely Never

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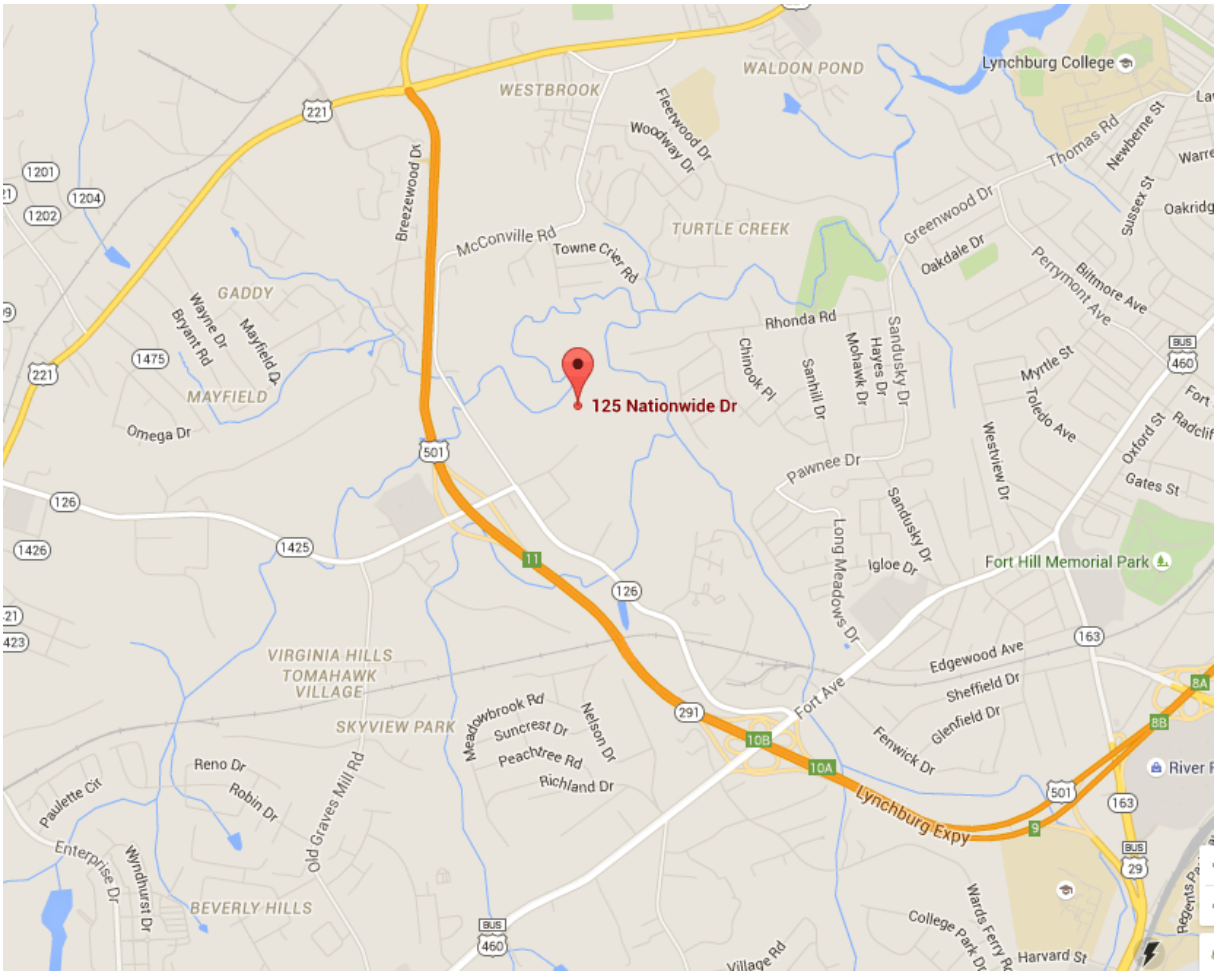
Upon completion, submit this information packet either *in person* or *by mail* to:

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



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You may keep this sheet as a reference.

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