



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 (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: _____



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

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

Family Medical History

Check here if adopted/unknown

CONDITION					Comments
	Mother	Father	Sibling(s)	Grandparents	
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					



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

Preventive Care	Date last done	Result
Colonoscopy		
Mammogram (females only)		

Medications		List all current medications or attach up-to-date and current list (attached list if necessary)		
MEDICATION	DOSE	SCHEDULE	PURPOSE	
Example only: <i>Metformin</i>	<i>500mg</i>	<i>1 pill twice a day</i>	<i>diabetes</i>	



Allergies		List all medication/food allergies or indicate: <input type="checkbox"/> <i>I have no known allergies.</i>			
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: <input type="checkbox"/> Marijuana <input type="checkbox"/> Ecstasy <input type="checkbox"/> Heroin <input type="checkbox"/> Meth(amphetamines) <input type="checkbox"/> Cocaine <input type="checkbox"/> Other: _____				
Review of Body Systems		Mark all symptoms that you are **currently** experiencing <u>at this time.</u>			
GENERAL	<input type="checkbox"/> Fevers or chills <input type="checkbox"/> Bingeing <input type="checkbox"/> Purging <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Excessive sweating		URINARY	<input type="checkbox"/> Pain with urination <input type="checkbox"/> Kidney stones <input type="checkbox"/> Trouble starting <input type="checkbox"/> Stopping stream	
EYES	<input type="checkbox"/> Burning <input type="checkbox"/> Irritation <input type="checkbox"/> Change in vision <input type="checkbox"/> Double vision		SKIN / BREAST	<input type="checkbox"/> Dark, velvety patches <input type="checkbox"/> NEW breast lump	
EARS / NOSE / THROAT	<input type="checkbox"/> Nasal congestion <input type="checkbox"/> Cough <input type="checkbox"/> Nosebleeds		HEMATOLOGIC	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Swollen glands	
RESPIRATORY	<input type="checkbox"/> Wheezing <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of breath		MUSCULOSKELETAL	<input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain: _____ <input type="checkbox"/> Tendon nodules (esp. Achilles) <input type="checkbox"/> Muscle aches	
CARDIOVASCULAR	<input type="checkbox"/> Chest pain <input type="checkbox"/> Chest pressure <input type="checkbox"/> Palpitations / irregular heartbeats		NEUROLOGICAL	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness	
GASTROINTESTINAL	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Acid reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain		SLEEP	<input type="checkbox"/> Loud Snoring <input type="checkbox"/> Daytime Fatigue <input type="checkbox"/> Insomnia	

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



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)
<i>Example: Low calorie diet</i>	<i>10 months</i>	<i>2002</i>	<i>30 lbs.</i>	<i>15 lbs.</i>
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®				
Ketogenic Diet:				
Other:				

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



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?		10. 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?	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you often feel tired, fatigued, or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has anyone observed you stop breathing during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have (or are you being treated for) high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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



CENTRA

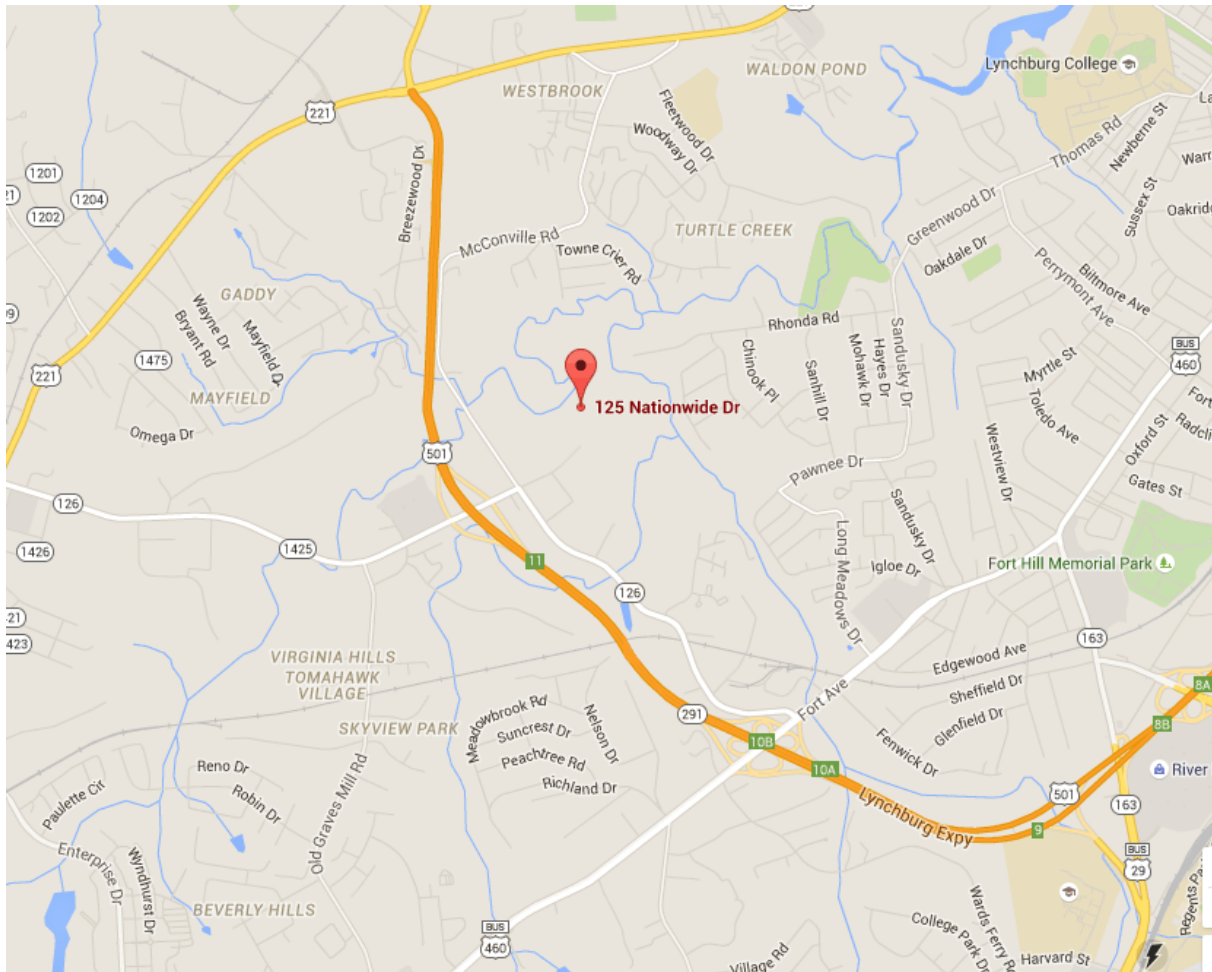
Centra Weight Loss Clinic Initial Appointment Questionnaire

**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: ____/____/____