Altru HEALTH SYSTEM

Altru's Weight Management Program
Health Assessment

PATIENT INFORMATION:

Last Name, First, Middle Initial			Date of Birth	Sex	Marital Status ☐ M ☐ D ☐ S ☐ W
Street Address			Home Phone		E-mail Address
City	State	Zip Code	Work Phone		Cell #

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care we must have complete answers. Please be thorough.

WEIGHT HISTORY:

Age	**Weight**	**Age**	**Weight**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any pertinent events that you feel contributed to your weight gain:

In your own words, please explain how you believe your life will change by losing weight?

Please list any diet programs you have tried.

Program	Dates	Duration	MD Supervised (Yes/No)	Max Loss
Jenny Craig				
Nutri System				
Weight Watchers				
Opti/Medi Fast				
Fen-Phen, Redux				
Meridia				
Lindora				
T.O.P.S.				
O.A.				
All others not listed above:				
Diet Pills (non-prescription):				
Acutrim				
Dexatrim				
Diurex				
Metabolife				
Other:				
Weight Loss Therapy:				
Psychotherapy				
Acupuncture				
Hypnosis				
Subliminal Tapes				
All others not listed above:				

For female patients only:

Age of first menstrual period: _____ Date of last period: _____

Are your periods: ☐ Regular ☐ Irregular

Pregnancy #1: Year _____ Weight at Start _____ At Delivery_____

Pregnancy #2: Year _____ Weight at Start _____ At Delivery_____

Pregnancy #3: Year _____ Weight at Start _____ At Delivery_____

Pregnancy #4: Year _____ Weight at Start _____ At Delivery_____

Did any of your children weigh nine pounds or greater at birth? ☐ Yes ☐ No

Miscarriages/abortions: _____

Infertility concerns/treatments:_____

Obstetric complications: _____

_____

_____

Have you gone through menopause? ☐ Yes Age _____ ☐ No

Have you ever had gestational diabetes? ☐ Yes ☐ No

FAMILY HISTORY:

Please indicate if there is a family history of any of the following and indicate relation:

Relation

☐ obesity _____

☐ diabetes _____

☐ high blood pressure _____

☐ heart disease _____

☐ high cholesterol _____

☐ bleeding tendency or blood disorder _____

☐ mental illness, depression _____

☐ eating disorder _____

☐ alcoholism/chemical dependency _____

☐ cancer (specify) _____

Please list all medications you currently use: (including non-prescription medications, vitamins, and herbal supplements)

Name	Strength	How Often	Purpose	When Started	Taken on a regular basis	Taken as needed

SLEEP HISTORY QUESTIONNAIRE

Please check the appropriate box or give short answers for the following:

1.	Do you feel sleepy or have "sleep attacks" during the day?	☐ Yes	☐ No
2.	Do you have trouble concentrating during the day?	☐ Yes	☐ No
3.	Do you awaken during the night?	☐ Yes	☐ No
4.	Do you awaken more than once?	☐ Yes	☐ No
5.	Do you awaken too early in the morning?	☐ Yes	☐ No
6.	Do you feel refreshed in the morning?	☐ Yes	☐ No
7.	Do you have restless sleep?	☐ Yes	☐ No
8.	Do you fall asleep driving?	☐ Yes	☐ No
9.	Do you snore?	☐ Yes	☐ No
10.	Does your spouse or sleep partner ever say that you stop breathing during the night?	☐ Yes	☐ No
11.	Are you currently being treated with CPAP or BiPap?	☐ Yes	☐ No

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3). Use the following scale to choose the most appropriate number for each situation:

0 = would never doze *1 = slight chance of dozing*
2 = moderate chance of dozing *3 = high chance of dozing*

Situation	**Chance of dozing**			
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in a public place (theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
Total	☐ 0	☐ 1	☐ 2	☐ 3

Please submit this form by mailing to:
Attn: Weight Management Program
Altru Health System
P.O. Box 6002
Grand Forks, ND 58206-6002