



The doctors' choice for long-term success

CONSULTATION FORM

PERSONAL INFO

Name: _____ Marital Status: _____ DOB: ___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: H (____) _____ W (____) _____ Cell (____) _____ Email: _____

Occupation: _____ How many children do you have? _____

How did you hear about our office? Patient Doctor Other American Society of Bariatric Medicine (ASBP)

HEALTH

Do you consider your health to be: Excellent Good Poor (circle one)

Please list any medications that you take _____

Please list any chronic medical conditions _____

LIFESTYLE AND HABITS

Do you like to exercise? Y N Do you exercise regularly? Y N If yes, how often and for how long? _____

Do you drink alcohol? Y N If yes, how much? _____ Do you smoke cigarettes? Y N If yes, how much? _____

PREVIOUS WEIGHT LOSS ATTEMPTS AND RESULTS

What is your approximate weight _____ height _____ desired weight _____

How long has it been since you were at your desired weight? _____

Describe previous weight loss experience and results _____

FOOD

How many people in your household? _____ Who cooks? _____ Who shops? _____

How often do you eat in a restaurant each week? _____ List the fluids you drink in a 24 hour period: _____

Do you have and food allergies or dietary restrictions? **Y N** If Yes, explain: _____

GOALS

List 3 ways that your life would be better if you weighed less: _____

How much weight would you like to lose through this program? _____

Rate your current commitment to change: (circle one) Lowest 1---2---3---4---5---6---7---8---9---10 Highest

Is there anything else we should know that will help us design a successful weight loss program for you?

Stop Here

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HT _____ Wt _____ BMI _____ 10% less _____ Goal _____ Total _____ Fam Hx Obesity _____

Hx/Meds: _____ Notes: _____

Initial Exam Scheduled/date _____

Lab Order _____ Pull _____ EKG Order _____ Pull _____ Referred by _____

PATIENT PREFERS: Mod VLCD LCD MIXED AS Exercise Class