



## Medical Centre

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### Weight Managment - Patient Intake Form

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Health Card # \_\_\_\_\_ Birth Date \_\_\_\_\_

Name \_\_\_\_\_  
(Last Name) (First Name) (Initial) (Maiden Name)

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#### Section I: Weight History

- 1) Current weight? \_\_\_\_\_ lbs  
Heaviest weight? \_\_\_\_\_ lbs What age? \_\_\_\_\_  
Lowest weight? \_\_\_\_\_ lbs What age? \_\_\_\_\_  
(maintained for at least 1 year since age 20)

For women: this  
would be non-  
pregnant weight

- 2) Which statement best describes your weight in childhood?
- ☐ I was overweight through most or part of my childhood.
  - ☐ I was mildly overweight or chubby through most or part of my childhood.
  - ☐ I was thin or "normal" weight throughout childhood.
- 3) Can you date the onset of your weight problem to a specific year? ☐ Yes ☐ No  
If yes, what age were you then? \_\_\_\_\_ years old  
During this time, was it a sudden rapid onset of weight gain? Yes No
- 4) Do you connect your weight problem to a specific life event? ☐ Yes ☐ No  
If yes, what was it? \_\_\_\_\_
- 5) Do you have a desired weight? ☐ Yes ☐ No  
If yes, what weight do you hope to achieve? \_\_\_\_\_ lb

## Section II: Lifestyle

1) Over the last 6 months have you been prevented from exercising because of your health?

☐ No ☐ Yes; If yes, please check all factors that prevent you from exercising:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Overweight      | <input type="checkbox"/> Arthritis, joint pain | <input type="checkbox"/> Limb amputation  |
| <input type="checkbox"/> Fracture/sprain | <input type="checkbox"/> Hemi/Quadriplegia     | <input type="checkbox"/> Lack of interest |
| <input type="checkbox"/> Heart problems  | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Dislike          |
| <input type="checkbox"/> Other: _____    |  |   |

2) **Daily Energy Expenditure**

Fill the average number of hours spent on respected activity levels considering the example activities below. Decimal values are allowed (e.g. 2.5, 0.25). The total must equal 24 hours.

\_\_\_\_ Hrs **Resting:** Sleeping, reclining

\_\_\_\_ Hrs **Very light:** Seated and standing activities, painting trades, driving, laboratory work, typing, sewing, ironing, cooking, playing cards, playing a musical instrument

\_\_\_\_ Hrs **Light:** Walking on a level surface at 2.5 to 3 mph, garage work, electrical trades, carpentry, restaurant trades, house cleaning, child care, golf, sailing, table tennis

\_\_\_\_ Hrs **Moderate:** Walking 3.5 to 4 mph, weeding and hoeing, carrying a load, cycling, skiing, tennis, dancing, weight training including rest between sets.

\_\_\_\_ Hrs **Heavy:** Walking with load uphill, tree felling, heavy manual digging, basketball, climbing, football, soccer

3) **Schedule: Please provide your typical weekly, work and social schedule**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Wake Time							
Work Hours							
Other Activities (social engagements etc.)							
Bed Time							

## Section II: Lifestyle Continued

### 4) Smoking history:

What statement best describes your smoking history?

☐ I have never smoked. (If you have never smoked go to question 6)

☐ I smoke (If so, how many cigarettes per day?) \_\_\_\_\_

☐ I quit smoking. (If so, how many years ago?) \_\_\_\_\_

For how many years have you smoked? \_\_\_\_\_

On average, how many cigarettes per day have you smoked over this time? \_\_\_\_\_

- 5) In the last 6 months, have you used recreational drugs? ☐ Yes ☐ No  
(Cannabis, marijuana, grass, hash, cocaine, etc.)

- 6) In the last 6 months, please describe your alcohol intake.

I am a non-drinker? ☐ Yes ☐ No

I drink alcohol most weeks? ☐ Yes ☐ No

I drink alcohol only on holidays and specific occasions? ☐ Yes ☐ No

I drink in binges? ☐ Yes ☐ No

If yes: How many days do the binges last? \_\_\_\_\_

How many times per year do they occur? \_\_\_\_\_

I have had a problem with alcohol in the past and now drink very little or nothing? ☐ Yes ☐ No

If yes: How long have you been alcohol free? \_\_\_\_\_ years \_\_\_\_\_ months

- 7) In the average week over the last 6 months, please estimate how much of each of the following would you use:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Beer (a 12 oz/360ml portion)							
Wine (a 5 oz/150ml portion)							
Spirits (Scotch, Gin Rum etc.) (a 1.5 oz/45ml portion)							

8) Eating Pattern :

Please fill out a typical day of eating:

Breakfast Time: _____	Lunch Time: _____	Supper Time: _____
AM snack Time: _____	Afternoon snack Time : _____	Evening snack Time: _____

Is there a particular time of day that you find challenging for eating or consume more than anticipated?

☐ No

☐ Yes

If yes, when? \_\_\_\_\_

And why? \_\_\_\_\_

Counting all meals and any snacks you may have, how many times a day do you eat: \_\_\_\_\_

Thinking about your **usual or normal week**, how many days out of the 7-day week do you:

Eat breakfast: \_\_\_\_\_

Eat brunch/lunch: \_\_\_\_\_

Eat dinner: \_\_\_\_\_

In a **usual or normal week**, please fill out how many days a week do you eat out at a fast food restaurant or other type of restaurant: \_\_\_\_\_

	Breakfast	Brunch/Lunch	Dinner
Fast food restaurants	_____ days/wk	_____ days/wk	_____ days/wk
Other types of restaurants	_____ days/wk	_____ days/wk	_____ days/wk

Please fill out how much you drink of:

Water:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Caffeinated coffee:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Decaf coffee:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Caffeinated tea:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Decaf tea:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Regular pop:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Diet pop:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Juice:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____
Milk:	<input type="checkbox"/> none	<input type="checkbox"/> cups per day:_____ or cups per week:_____

9) Do you consider yourself an “emotional eater”? ☐ Yes ☐ No

10) Have you ever had a diagnosis of:

Anorexia Nervosa? ☐ Yes ☐ No

Bulimia? ☐ Yes ☐ No

Binge Eating Disorder? ☐ Yes ☐ No

Night Eating Disorder? ☐ Yes ☐ No

Other: \_\_\_\_\_

12) Have you ever been referred to an Eating Disorder Clinic? ☐ Yes ☐ No

13) Have you ever made yourself vomit after overeating? ☐ Yes ☐ No

14) Do you have times when you binge?  
☐ Yes ☐ No (If no, skip to question 14)

A “binge” is a large amount of food eaten in a short short time (usually less than 2 hours) and usually outside of regular meal times

If Yes, which of the following might cause you to binge (check all that apply):

<input type="checkbox"/> No particular reason	<input type="checkbox"/> Boredom	<input type="checkbox"/> Sadness/depression	<input type="checkbox"/> Anger
<input type="checkbox"/> Relationship issues	<input type="checkbox"/> Hunger	<input type="checkbox"/> Parenting difficulties	<input type="checkbox"/> Stress

After you binge, do you have feelings of self-criticism, depression or guilt?

☐ Yes ☐ No

Over the last 6 months, how often would you binge:

<input type="checkbox"/> Never	<input type="checkbox"/> every day	<input type="checkbox"/> Once a week	<input type="checkbox"/> More than once a week
<input type="checkbox"/> Several times a month	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Premenstrual week only	

**Part III: Prior weight management strategies:**

1) Have you ever taken medications for weight loss?

☐ No (skip to question 2)

☐ Yes If Yes, please check all medications that apply:

☐ Xenical ☐ Meridia ☐ Victoza ☐ Saxenda ☐ Fen-Phen

☐ Ionamine ☐ Other: \_\_\_\_\_

2) Have you ever had surgery for weight loss?

☐ No (skip to question 3)

☐ Yes If Yes, please check what type of surgery:

☐ Lap-band ☐ Roux-en-Y gastric bypass

☐ gastric sleeve ☐ Vertical banded gastroplasty (stomach stapling)

☐ Duodenal switch ☐ Biliopancreatic diversion

☐ I had bariatric surgery but cannot recall what kind

3) Please complete this table on types of weight loss programs you have tried. Include the year, number of months in the program, pounds lost and how long the weight was kept off.

If you answered yes to Question 1 or 2, please include these answers in this table.

Program	Year	Number of Months	Weight loss in lbs	How long did you keep the weight off?
Here are some examples of programs: Weight Watchers, TOPS, medically supervised programs, Overeaters Anonymous, Registered Dietitian, or self-directed (South Beach, Atkins, GI Diet, etc)				

## Part IV: Medical Conditions

1) In the last year, have you had? (Check all that apply)

- ☐ low back pain    ☐ painful feet    ☐ knee pain    ☐ hip pain  
☐ shortness of breath    ☐ heartburn or hyperacidity  
☐ stress incontinence (women)    ☐ chest pain at rest or with exertion

**For women only :**

- ☐ irregular periods    ☐ acne    ☐ hair growth above lip

How many blocks can you walk without being short of breath? \_\_\_\_\_

2) Have you ever been told you have any of the following conditions?

If Yes, when did you find out?

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Month & Year
Aortic Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood sugar or diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatty liver	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack/angina/coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been hospitalized for a heart attack or angina or stroke/TIA?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deep vein thrombosis (DVT)/ pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout or high uric acid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had your gallbladder removed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes to sleep apnea are you presently using a CPAP machine?	<input type="checkbox"/>	<input type="checkbox"/>	_____

3) The following questions are related to sleepiness:

Are you likely to fall asleep during meetings? ☐ No ☐ Yes

Are you likely to fall asleep while watching TV? ☐ No ☐ Yes

Are you likely to fall asleep while waiting for a traffic light? ☐ No ☐ Yes

Have people ever complained about your snoring? ☐ No ☐ Yes ☐ Unknown\*

Has your partner ever expressed concern that you stop breathing during your sleep? ☐ No ☐ Yes ☐ Unknown\*

*\*If there is no one available to observe your sleep.*

4) Do you have any other medical conditions or ongoing treatments at this time?

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5) Please list any hospital admissions you have had and the last year it happened:

Reason for admission:

Year:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

#### Part V: Medications, Vitamins, Supplements, Allergies

Prescription Medication Name	Dose	Number of times taken DAILY or as needed	OR	Number of times taken MONTHLY

## Part V: Medications, Vitamins, Supplements, Allergies

List over-the-counter medications, supplements, or herbal preparations:

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Allergies to medications:

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Allergies or intolerances to food or environment:

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## Part VI: Family History

- 1) Were you adopted? ☐ Yes ☐ No

If Yes, and you do not know about your biological relatives, go to Part VII.

- 2) For first degree relatives (parents, siblings, children) is there a history of weight issues?

☐ Yes ☐ No

If Yes, who struggled with weight? \_\_\_\_\_

- 3) Have first degree relatives (parents, siblings, children) had any of the following health conditions? (females before age 65 or males before age 55)

☐ Diabetes (adult onset) ☐ Angina ☐ Heart attack ☐ Stroke

- 4) History of sudden cardiac death? ☐ No ☐ Yes

## Part VII: For Women Only

- 1) Last menstrual period \_\_\_\_\_ Year/Month ☐ Unsure

- 2) If you are having menstrual periods:

Are they regular? ☐ Yes ☐ No

Are they regular because of medications? ☐ Yes ☐ No

If yes, please list which medications: \_\_\_\_\_

- 3) If your menstrual periods have stopped:

Was it due to menopause? ☐ Yes ☐ No

Was it due to hysterectomy? ☐ Yes ☐ No

Was it some other reason? ☐ Yes: \_\_\_\_\_

- 4) Please list the number of full term pregnancies and their effect on your weight:

Did you have gestational diabetes during pregnancy? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Pregnancy	Year	Did your weight normalize after this pregnancy?		If yes, for how long did it stay normal (in months)?
#1		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
#2		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
#3		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

## Part VIII: Psychiatric History

**Have you ever been treated for any of the following (check all that apply):**

<input type="checkbox"/>	Depression	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Alcohol Problems	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	OCD	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	Personality Disorder
<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	Anorexia / Bulimia	<input type="checkbox"/>	Suicidal / self-injuring behavior
<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	Binge-eating	<input type="checkbox"/>	Problems coping with stress
Other: _____							

**Have you ever been hospitalized for psychiatric reasons?** ☐ Yes ☐ No

(If yes) Provide details: \_\_\_\_\_

**Have you ever attempted to kill or harm yourself?** ☐ Yes ☐ No

**Do you currently have any thoughts about self harm or suicide?** ☐ Yes ☐ No

**Have you been prescribed psychitric medication in the past** ☐ Yes ☐ No

(If yes) Please list: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





## Medical Centre

### Epworth Scale

Name \_\_\_\_\_

0 = no chance of dozing

1 = sl. chance of dozing

2 = mod. chance of dozing

3 = high chance of dozing

#### Situation

#### Chance of Dozing

Sitting and reading

\_\_\_\_\_

Watching TV

\_\_\_\_\_

Sitting inactive in a public place

\_\_\_\_\_

(e.g a theater or a meeting)

As a passenger in a car for an hour without a break

\_\_\_\_\_

Lying down to rest in the afternoon when circumstances permit

\_\_\_\_\_

Sitting and talking to someone

\_\_\_\_\_

Sitting quietly after a lunch without alcohol

\_\_\_\_\_

In a car, while stopped for a few minutes in traffic

\_\_\_\_\_

**Total:** \_\_\_\_\_

**0-9** Lower likelihood of OSA

**10-24** Higher likelihood of OSA