



Patient Weight Loss & Medical History Questionnaire

NAME: _____ Sex: M F Age: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Current Weight: _____ Current Height _____ BMI _____

INSURANCE INFORMATION

Insurance Name: _____

Does your Health Insurance cover weight loss surgery ? _____

If so what Pre-Approval Requirements do they have ?

Pre-Op Weight Loss ? _____ lbs

Medically Supervised Weight Loss Program Required _____, Length of time required _____

Duration of Obesity ? _____ Smoking cessation ? _____

Mental Health Clearance ? _____ Psychological or IQ testing ? _____

Other Requirements ? _____

PREVIOUS ATTEMPTS AT WEIGHT REDUCTION:

How many years have you been overweight? _____

Please estimate your weight at the following times:

Birth: _____

Marriage: _____

Lowest Weight in Past 5 Years: _____

Highest Weight in Past 5 Years: _____

1 st Pregnancy - year _____	start weight _____	weight at delivery _____
2 nd Pregnancy - year _____	start weight _____	weight at delivery _____
3 rd Pregnancy - year _____	start weight _____	weight at delivery _____
4 th Pregnancy - year _____	start weight _____	weight at delivery _____

FOOD PREFERENCES

Rate the following foods from 1 - 5. 1 for don't like very much and 5 for like very much (most likely to make you go off a diet)

_____ soda/soft drinks	_____ French fries	_____ chips/salty snacks
_____ steaks/chops	_____ candy	_____ potatoes
_____ chocolate	_____ pasta	_____ cookies
_____ pizza	_____ cakes/pies	_____ salad dressings
_____ fried foods	_____ bread	

DIET PROGRAMS AND SUPPLEMENTS

Please indicate which of the following diets or plans you have tried:

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
_____ Weight Watchers	_____	_____	_____	_____
_____ Jenny Craig	_____	_____	_____	_____
_____ Metabolife	_____	_____	_____	_____
_____ Medifast	_____	_____	_____	_____
_____ Nutri/System	_____	_____	_____	_____
_____ Atkins Diet	_____	_____	_____	_____
_____ Herbalife	_____	_____	_____	_____
_____ SlimFast	_____	_____	_____	_____
_____ Grapefruit Diet	_____	_____	_____	_____
_____ Liquid Diet	_____	_____	_____	_____
_____ Pritikin Diet	_____	_____	_____	_____
_____ Optifast	_____	_____	_____	_____
_____ T.O.P.S	_____	_____	_____	_____

List any other physicians - supervised Weight loss attempts: _____

WEIGHT-LOSS MEDICATION HISOTRY

Please indicate if you have taken any of the following medications to lose weight

MEDICATION	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
_____ Amphetamines	_____	_____	_____	_____
_____ Phentermine (Adipex, Fastin, Pondimen)	_____	_____	_____	_____
_____ Phen-Fen	_____	_____	_____	_____
_____ Dexfenfluramine (Redux)	_____	_____	_____	_____
_____ Xenical (Orlistat)	_____	_____	_____	_____
_____ Meridia (Sibutramine)	_____	_____	_____	_____
_____ Ozempic/Wegovy	_____	_____	_____	_____
_____ Mounjaro/Zepbound	_____	_____	_____	_____

NON-DIETARY THERAPY: Please indicate if you have tried any of the following weight loss therapies.

THERAPY	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
____ Exercise	_____	_____	_____	_____
____ Hypnosis	_____	_____	_____	_____
____ Behavior Modification	_____	_____	_____	_____
____ Acupuncture	_____	_____	_____	_____

List any other weight loss methods you have tried: _____

PREVIOUS WEIGHT LOSS SURGERY: Yes No

Surgery	Type	Date	Surgeon	Wt. Loss

UPDATED 2/7/2025