The Doctors' Weight Management Program – Medical Evaluation (Part I)

Please answer the following questions and leave this with a Health Educator after Orientation.

Name _____ **Date** _____

Have you participated in this program before? **Yes** **No**

If yes, did you participate in the "maintenance" phase? **Yes** **No**

Are you 18 years of age or OLDER? **Yes** **No**

What is your *approximate:* Current Weight? _____ **Height?** _____

Do you have a chronic or current condition that is being followed by a doctor?	Yes	No	Past
Do you have pre-diabetes, Type 1, Type 2 or gestational diabetes?	Yes	No	Past
Are you allergic to milk, eggs, soy, corn, nuts, wheat gluten or artificial sweeteners?	Yes	No	Past
Do you have lactose intolerance?	Yes	No	Past
Do you have heart disease that limits your activity?	Yes	No	Past
Do you have heart irregularity or have you had an abnormal EKG/stress test?	Yes	No	Past
Do you have liver disease?	Yes	No	Past
Do you have kidney disease, a history of kidney failure, or dialysis?	Yes	No	Past
Do you have gallbladder disease or gallstones?	Yes	No	Past
Do you have high blood level of uric acid or gout?	Yes	No	Past
Are you receiving chemotherapy or radiation therapy for cancer?	Yes	No	Past
Do you have cancer?	Yes	No	Past
Do you have abdominal pain/cramps/bloating, indigestion or heartburn?	Yes	No	Past
Do you have regular or occasional nausea, or vomiting?	Yes	No	Past
Do you have irregular bowel movements, constipation or diarrhea?	Yes	No	Past
Do you have stomach ulcers?	Yes	No	Past
Do you have frequent headaches?	Yes	No	Past
Do you currently have fainting dizziness change of vision?	Yes	No	Past

The Doctors' Weight Management Program – Medical Evaluation Part I

Please answer the following questions and bring this completed form to your Pre-diet Evaluation.

Name _____ **Date** _____

Do you currently have rapid or irregular heartbeat, shortness of breath or asthma?	Yes	No	Past
Do you currently have swelling of the legs and/or feet or cramping of the extremities?	Yes	No	Past
Do you have an irregular menstrual cycle? (if applicable)	Yes	No	Past
Do you have tuberculosis?	Yes	No	Past
Do you have thyroid disorder?	Yes	No	Past
Do you have hepatitis / HIV?	Yes	No	Past
Do you have anemia?	Yes	No	Past
Do you have sleep apnea/CPAP?	Yes	No	Past
Do you have arthritis?	Yes	No	Past
Do you have anorexia nervosa or bulimia?	Yes	No	Past
Do you have psychiatric conditions?	Yes	No	Past
Do you currently use alcohol?	Yes	No	Past
Do you have physical limitations?	Yes	No	Past

Medical illnesses/events

Do you have any surgeries scheduled within the next 3 months?	Yes	No
Have you had stroke/heart attack or blood clots?	Yes	No
Have you had kidney disorders/transplant?	Yes	No
Have you had liver disorders/transplant?	Yes	No
Have you had bariatric surgery or the placement of a Lap-band?	Yes	No
Are you over the age of 70 *and* have a history of dizziness, TIAs, or strokes?	Yes	No
Are you pregnant or nursing (less than 12 weeks)? (if applicable)	Yes	No
Is there any chance you could be pregnant? (if applicable)	Yes	No