Weight History

Please fill all of these forms out as completely as possible. Date: ________

Name ________________ Age: _______ Phone: __________

Sex: Male _____ Female _____

Weight History

What is your approximate weight? _____pounds

What is your height? _____ inches

How old were you when you first became more than 20 pounds overweight? _____

What was your weight in high school? ____ pounds

Were you overweight as a child? Yes____ No____

What was the highest weight you have been in your life? ____ Pounds

Have any of your close relatives been overweight or had obesity?

Mother Father Siblings (*check all that apply*)

Do you have any of the following or do any of the below apply to you?

- < 18 years old
- Pregnant/breastfeeding
- Type 1 DM
- Hypersensitivity to semaglutide or any components of this medication
- Personal or family history of medullary thyroid carcinoma
- History of multiple endocrine neoplasia syndrome
- History pancreatitis
- End stage renal disease (on dialysis)
- BMI < 25

☐ None of the above apply to me. Pt initials : ____

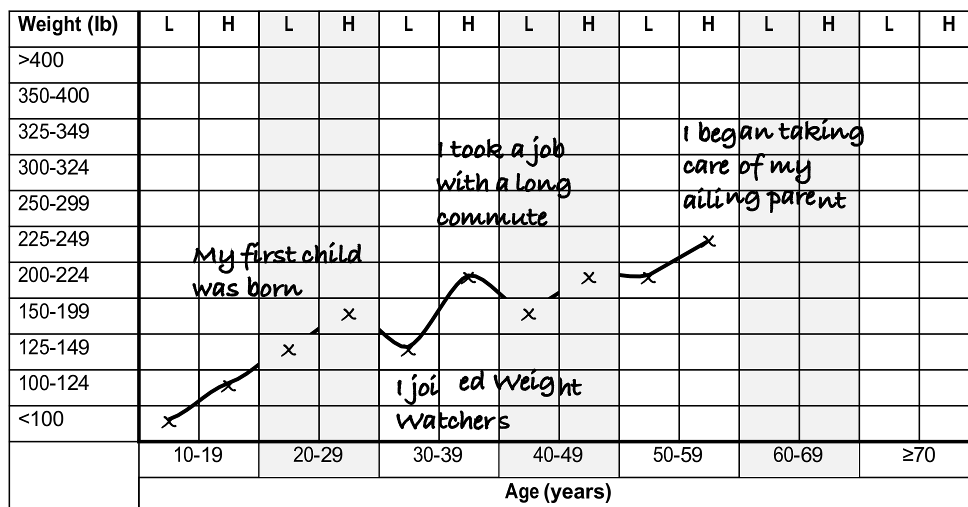
Weight History

Weight History

Chart Your Weight History

To the best of your recollection, indicate your lowest (L) and highest (H) weight during each time interval by putting an X in the corresponding box in the chart below, then connect the X's with a line. Write down anything you remember that might have contributed to your weight gain or weight loss.

Example:



Weight (lb)	L	H	L	H	L	H	L	H	L	H	L	H	L	H
>400														
350-400														
325-349														
300-324														
250-299														
225-249														
200-224														
150-199														
125-149														
100-124														
<100														
	10-19		20-29		30-39		40-49		50-59		60-69		≥70	
	Age (years)													

Weight History

Weight Management History

Have you ever been treated by a doctor for your weight?

Yes __No__ When (year)? ____

Were you successful? Yes ___ No ___ How much weight did you lose? _______

Have you ever consulted with a registered dietitian? Yes___ No ___

Have you ever participated in a weight loss program? Yes ____ No ____

Please indicate which of the following weight loss programs that you have tried:

Program	Length of Time	Weight Lost	When?
Diet Center			
HMR			
Jenny Craig			
Lindora			
Medi-Fast			
Nutri-System			
Opti-fast			
Pro-Cal			
Weight Watchers			
Other			
Other			

Have you ever taken medication to lose weight? (*check all that apply*)

Medication	Was it effective?	Did you have side effects that made you stop taking it? (*If so, list side effect*)	When did you take it? (*List years*)
Phentermine (e.g., Adipex)			
Tenuate (diethylpropion)			
Belviq (lorcaserin)			
Contrave (naltrexone/ bupropion)			
Qsymia (phentermine/ topiramate)			

Weight History

Medication	**Was it effective?**	**Did you have side effects that made you stop taking it? (*If so, list side effect*)**	**When did you take it? (*List years*)**
Saxenda (liraglutide for weight loss)			
Xenical (prescription orlistat)			
Alli (over the counter orlistat)			
Topamax (topiramate)			
Glucophage (metformin)			
Victoza (liraglutide for type 2 diabetes)			
Meridia (sibutramine)			
Phen/Fen or fenfluramine			
Herbal: ______________			
Other: _______________			

Surgery

Have you ever had bariatric surgery? Yes ___ No ____

If so, what type? _____ what year? ____

How much weight lost? ____

How much weight gained back? _____

Weight History

Dietary Habits

Please describe your *most common* habits for each category. Enter 0 if you do not eat that meal or snack.

Meal/Snack	**Time of Day**	**Place (home, work, car, restaurant, take-out), Typical Foods**
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening snack		
Late night snack		
Grazing (eating small amounts frequently)		

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?

Yes____ No ____ If yes, about how many times? ____

Do you sometimes make yourself vomit as a means to control your weight?

Yes____ No ____

Have you ever been diagnosed with (*check all that apply*):

Binge eating disorder ____ Anorexia nervosa____ Bulimia ____

Weight History

Physical Activity

Do you exercise regularly? Yes____ No____
If "yes," what kind of exercise? ____

How many times per week? ___

How many minutes per session? ____

How many hours per day do you watch television? __

Do you work outside the home? Yes __ No __
If yes, what type of work? ____

Do you do housework? Yes __ No __ How often?_______________________

Do you walk to work/school? Yes____ No____ Sometimes ____ How far? _______

Feelings About Eating and General Mood

Do you feel distressed about episodes of overeating? Yes ____ No____

Do you often feel like you have no control over your eating or that you are unable to stop eating? Yes____ No____

Are you often embarrassed by how much you eat? Yes____ No____

Do you frequently feel disgusted with yourself for overeating or do you feel guilty for overeating? Yes____ No____

Check the answer that best describes your feelings:

I have little interest or take little pleasure in doing things.
☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel down, depressed, or hopeless.
☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have trouble falling or staying asleep.
☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Weight History

I sleep too much.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel tired or have little energy.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have a poor appetite because of my mood.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I overeat because of my mood.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel bad about myself. I feel like a failure and/or I have a lot of guilt.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have trouble concentrating on things or making decisions.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I move or speak slowly in a way that other people notice.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I'm restless and feel like I have to keep moving.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I think about hurting myself or that I would be better off dead.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How difficult have these symptoms made it for you to do your work, take care of things at home, or get along with other people?

☐ Extremely difficult ☐ Very difficult ☐ Somewhat difficult ☐ Not at all difficult

Weight History

Social Support

Does your family support your efforts to have a healthier lifestyle? Yes ___ No __

Do you see a counselor of any kind (e.g., therapist, religious leader, addiction counselor, psychologist, psychiatrist)? Yes ___ No ___

Do you belong to any support groups (e.g., Weight Watchers, Overeaters Anonymous, Alcoholics Anonymous, Alanon, etc.)? Yes ___ No ___