UNC Physicians Network
Medical Weight Clinics Intake Form

Personal Information

Name: ______________________________ Date: ________________

Motivations & Goals

What is your main reason for obesity treatment? *Check all that apply:*
□ I want this for myself ("self-motivation").
□ A family member insisted that I lose weight.
□ My physician has recommended weight loss.
□ Other____

What is your motivation for obesity treatment? *Check all that apply:*
□ To improved appearance.
□ To be more active.
□ To have a better quality of life.
□ To improve in my health conditions.
□ Other____

What treatments are you interested in pursuing? *Check all that apply:*
□ Lifestyle changes only
□ Lifestyle changes and weight loss medications
□ I'm open to surgical weight loss

Overall Goals:
□ No weight goal, only to feel better.
□ No weight goal, improvement in _______________________
□ Weight goal of __________ lb

Weight History

Normal weight upon birth? **□ Yes □ No**
Normal weight during childhood? **□ Yes □ No**
Highest adult weight_________lb / Lowest adult weight_________lb
Lowest adult weight on a diet or weight loss program_________lb

Please describe when and how you started gaining weight.

____
____
____
____
____

Is there evidence of a genetic history of obesity? *Check all that apply:*
□ There is a strong family history of obesity.
□ Obesity started early and has been progressive during my life.
□ I was excessively hungry as a child.

Are there any other reasons for weight gain? *Answer any that apply.*
Shift work with associated weight gain of__________lb
I quit smoking with associated weight gain of__________lb
Past or present medications associated with weight gain of __________lb

Female patients only:
I have post-partum weight retention of__________lb
I have menopause associated weight gain of__________lb

Diet History

What diets have worked for you in the past? *Please list all that apply.*

____
____
____
____

What is the most weight that you have lost __________lb

How long did you maintain your weight loss? ___________________________

Are you currently working with a Registered Dietitian? □ Yes □ No

Please write down everything you ate in the previous 24 hours starting with *yesterday morning.*
(*Please include alcohol and sugar-free beverages as well.)*

Meal	Time	Food and Drinks Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Do you have excessive hunger within 1-2 hours of having a regular meal? □ Yes □ No

At times I eat when I am not hungry. □ Yes □ No

If yes, describe when this happens and why?

____

I eat for comfort when I am stressed or emotional. □ Yes □ No

If yes, describe when this happens and why?

____

There are times when I eat and it feels like I can't stop. □ Yes □ No

If yes, describe when this happens and why?

____

I try to manage my weight by vomiting, using laxatives, diuretics, or excessive exercise. □ Yes □ No

If yes, when was the last time?

____

Sometimes I find food on my bed which I do not remember eating. □ Yes □ No

If yes, how often does this happen?

____

I eat late at night or I wake up at night and eat. □ Yes □ No

Please list foods that you eat frequently.

____

____

Physical Activity History

At work I am? □ Constantly moving. □ Somewhat active. □ Not active

I exercise regularly. □ Yes □ No

Type of exercise that I usually do: ____

Amount of time I exercise: ___________ **minutes.**

Number of times I exercise in a week? __________________

I have been unable to exercise because?

____

The physical activities I enjoy are?

____

Other activities that are limited by my weight: ____

Sleep History

I sleep an average of ______ hours at night.

I sleep at _____________ am/pm and wake up at ___________ am/pm.

I wake up __________ times a night for ________________________________

My last drink of the day is at __________.

I have been diagnosed with Obstructive Sleep Apnea (OSA):
□ Yes (skip STOP-BANG questions)
□ No

I currently use a CPAP or other device for OSA: □ Yes □ No

STOP-BANG questions. You may SKIP if already diagnosed with OSA. *(1 point for each yes)*

1. I snore loudly: O Yes O No
2. I feel tired, fatigued, or sleepy during the daytime: O Yes O No
3. I have been observed me stop breathing, gasp, or chock when I sleep: O Yes O No
4. I have a diagnosis or are treated for high blood pressure: O Yes O No
5. My BMI is > 35: O Yes O No
6. My age is >50: O Yes O No
7. My neck circumference is >17 inches (male) or >16 inches (female): O Yes O No
8. I am a male: O Yes O No

Score: ____/8

Stress/Mood History

My stress level during the past year on a scale of 1 to 10: _________________

When I feel stressed I tend to?
____

The main cause of my stress is?

____
____

Any thoughts about harming yourself or wanting to die: □ Yes □ No

I have done self-harming behaviors such as cutting myself: □ Yes □ No

Have you been to the ER or hospitalized for mental health reasons: □ Yes □ No

Any alcohol or substance abuse, including prescription abuse: □ Yes □ No

PHQ-9 (depression questions)				
Over the last 2 weeks how often have you been bothered by any of the following	**Not at all**	**Several days**	**More than half of days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself/family down	0	1	2	3
Trouble concentrating on things such reading or watching television	0	1	2	3
Moving or speaking so slowly that people have notice or being so fidgety or restless that you have been moving around a lot more.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself.	0	1	2	3

Total Score: _________ / 27

Medical History

History of Glaucoma? ☐ Yes ☐ No

History of Palpitations? ☐ Yes ☐ No

History of Chest pain? ☐ Yes ☐ No

History of Headaches? ☐ Yes ☐ No

History of Kidney Stones? ☐ Yes ☐ No

History of Seizures? ☐ Yes ☐ No

History of Head trauma? ☐ Yes ☐ No

History of radiation to the brain? ☐ Yes ☐ No

History of Pancreatitis? ☐ Yes ☐ No

Personal or family history of thyroid cancer? ☐ Yes ☐ No

Female patients only:

Date of last period _______________

Current contraceptive/Birth control use:

☐ Oral contraception ☐ IUD (Mirena, copper IUD)

☐ Tubal ligation (tubes tied) ☐ Hysterectomy and/or ovaries removed

☐ Other _________________________

Previous Use of Weight Loss Medications

Drug	Amount of weight loss	Side-effects
☐ Phentermine		
☐ Metformin		
☐ Topiramate (Topamax)		
☐ Wellbutrin (bupropion)		
☐ Qsymia (Phentermine/Topiramate)		
☐ Contrave (naltrexone/bupropion)		
☐ Belviq (lorcaserin)		
☐Saxenda/Victoza (liraglutide)		
☐ SGLT-2 inhibitor		
☐ Other		