MRN:

COMMUNITY CARE
ENDOCRINOLOGY
of Community Care Physicians

What is Medically Supervised Weight Management?

- We integrate medical evaluation, nutritional counseling, exercise guidance and behavior modification to help you reach your goals.

What should I expect in the beginning of my program?

- You will meet with one of our providers and members of our staff for an initial appointment. You will receive a comprehensive evaluation that will include review of your medical, nutrition, exercise, and behavioral history.
- Lab work and/or testing may be recommended/ordered.

How often do I come in?

Depending on your needs, we will see you approximately every 4 weeks.

Will my insurance cover this?

- Weight Management visits are covered by **most** major insurance carriers.
- Certain insurance plans may have restrictions regarding the number of visits that they allow and/or diagnosis used.
- Weight loss medication coverage will depend on your insurance.

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2125 River Road, Suite 303B, Niskayuna, NY 12309
p (518) 213-6910 | f (518) 213-6915

1783 Route 9, Suite 203, Clifton Park NY 12065
P (518) 213-6910 | f (518) 213-6916

Weight Management

Thank you for your interest in Weight Management. Community Care Endocrinology is here to support you in this endeavor by providing medically supervised weight. You have been scheduled for your first appointment with

_____ on for an appointment_____ at _____ at the following location:

- ☐ 1783 Route 9, Suite 203, Clifton Park, NY 12065
- ☐ 2125 River Road, Suite 303B, Niskayuna NY 12309
- ☐ _____

For us to prepare for your appointment, we require that you complete this pre- visit questionnaire. **Please answer all questions completely and honestly.**

We look forward to meeting you!

Sincerely,
The Community Care Patient Education and Wellness Team

Community Care Endocrinology

MRN:

PATIENT QUESTIONNAIRE

Name: _____Date of Birth: _____

Phone #: _____

Primary Care Physician: _____

Specialists: _____

PLEASE LIST ANY MEDICATIONS AND OR SUPPLEMENTS THAT YOU ARE TAKING AND DOSAGE:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ANY DRUG ALLERGIES

_____

FOR FEMALE PATIENTS:

DO YOU USE A FORM OF BIRTH CONTROL? (CIRCLE) YES NO

IF YES, WHAT DO YOU USE? _____

MENSTRUAL CYCLE: (CIRCLE) REGULAR , IRREGULAR

ARE YOU: (CIRCLE ANY THAT MAY APPLY) TRYING TO CONCEIVE , MENOPAUSAL , PERI-MENOPAUSAL

MEDICAL HISTORY: (PLEASE MARK ALL THAT APPLY)

- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Heart Problems** -Heart Attack, Coronary Disease, Valve Problems, Congestive Heart Failure, Cardiomyopathy, Heart murmur, other: _____
- ☐ **Cerebrovascular Disease**- Stroke, Mini-Stroke, Carotid Artery Disease, other: _____
- ☐ **Peripheral Vascular Disease**
- ☐ **Lung Problems** - COPD, Asthma, pulmonary hypertension, interstitial lung disease, restrictive lung disease, other: _____
- ☐ **Sleep Problems**- Insomnia, Snoring, Sleep Apnea, CPAP, other: _____
- ☐ **Diabetes**
- ☐ **Thyroid Problems** - under or overactive thyroid, thyroiditis, thyroid nodule, thyroid removed, other: _____
- ☐ **Kidney Disease** - kidney failure, protein in urine, nephritis, polycystic kidneys, other: _____
- ☐ **Kidney Stones**
- ☐ **Liver Disease** -Hepatitis, Fatty Liver, Cirrhosis, other: _____
- ☐ **Gout**
- ☐ **Gallstones**
- ☐ **GYN Problems** -Polycystic Ovarian Syndrome, Irregular Menses, other: _____
- ☐ **Infertility**
- ☐ **Osteoarthritis** -Back, Neck, Hips, Knees, Feet, other: _____
- ☐ **Rheumatologic Disorder** -Rheumatoid Arthritis, Lupus, Sarcoidosis, Fibromyalgia, other: _____
- ☐ **Mood Disorder** - Anxiety, Depression, Stress, Bipolar Disorder, other _____
- ☐ **Cancer** – type:_____
- ☐ **Eating Disorder**- Anorexia, Bulimia, Binge Eating, Night Eating, other:_____
- ☐ **Neurological Disorder**- Seizures, Migraine, Neuropathy, RSD, other:_____
- ☐ **Gastrointestinal Problems-** Irritable Bowel, Inflammatory Bowel, Colitis, Diverticulitis, Celiac Disease, Reflux, Constipation, other: _____
- ☐ **Addiction –** type: _____
- ☐ **Other:**_____

MRN:

WHAT IS YOUR MOTIVATION TO LOSE WEIGHT?

- ☐ Health
- ☐ Appearance
- ☐ Reduce Medications
- ☐ Improve Mobility/ Exercise Tolerance
- ☐ Other:_____

WHAT IS THE MOST YOU HAVE EVER WEIGHED? _____AT WHAT AGE? _____

WERE YOU OVERWEIGHT OR OBESE AS AN ADOLESCENT/TEENAGER? (CIRCLE) YES NO

HAVE YOU GAINED WEIGHT IN THE PAST YEAR? (CIRCLE) YES NO

- ☐ If yes, how much weight have you gained? _____
- ☐ If yes, have you had any major life changes in the past year?

_____

WHAT IS YOUR PERSONAL GOAL WEIGHT? _____

WHAT DIETS HAVE BEEN MOST SUCCESSFUL FOR YOU IN THE PAST AND WHY?

_____

_____

WHY HAVE PREVIOUS DIETS FAILED?

_____

_____

HAVE YOU HAD ANY SURGICAL BARIATRIC PROCEDURES? (CIRCLE) YES NO

- ☐ If yes, explain: _____

_____

HAVE YOU EVER TAKEN OVER THE COUNTER SUPPLEMENTS FOR WEIGHT LOSS? (CIRCLE) YES NO

- ☐ If yes, what supplement _____

_____

HAVE YOU EVER TAKEN ANY PRESCRIPTION MEDICATIONS FOR WEIGHT LOSS? (CIRCLE) YES NO

- ☐ If yes, what medication (circle) Phentermine, Diethylpropion, Xenical, Phendimetrazine, Meridia, Belviq, Qsymia, Contrave, Saxenda, Wegovy, other:

_____

- ☐ Did you lose weight with this medication? (circle) YES NO
- ☐ Did you experience any side effects on this medication? (circle) YES NO

If yes, please explain: _____

FOOD ALLERGIES/SENSITIVITIES

DO YOU HAVE ANY DIETARY RESTRICTIONS? (CIRCLE) YES NO

- ☐ Avoid Dairy
- ☐ Avoid Beef
- ☐ Avoid Pork
- ☐ Gluten Free
- ☐ Vegetarian
- ☐ Pescaterian (Vegetarian, however will eat fish)
- ☐ Lacto-Ovo Vegetarian (will eat eggs and dairy)
- ☐ Ovo Vegetarian (will eat eggs, no dairy)
- ☐ Lacto Vegetarian (will eat dairy, no eggs
- ☐ Vegan (no foods derived from animals)
- ☐ Other_____

DO YOU HAVE ANY FOOD ALLERGIES? (CIRCLE) YES NO

- ☐ If yes , what food(s) _____
- ☐ What type of reaction do you have? _____
- ☐ Do you have an epi-pen? _____

DO YOU HAVE ANY FOOD SENSITIVITIES? (CIRCLE) YES NO

- ☐ If yes, what food(s)_____
- ☐ What type of reaction do you have? _____

DO YOU HAVE ANY SENSITIVITIES TO GLUTEN, LACTOSE, ARTIFICIAL SWEETENERS? (CIRCLE) YES NO

- ☐ If yes, explain_____

MRN:

EATING HABITS

HOW MANY TIMES PER WEEK DO YOU EAT AT RESTAURANTS OR TAKE-OUT MEALS? _____

WHAT TYPE OF RESTAURANTS DO YOU FREQUENT? _____

☐ Fast Food ☐ Sit – Down / Chain ☐ Pubs ☐ Deli Fine Dining

DO YOU SKIP MEALS? (CIRCLE) YES NO

DO YOU FREQUENTLY SKIP BREAKFAST? (CIRCLE) YES NO

WHO LIVES WITH YOU? _____

DO YOU HAVE SUPPORT AT HOME TO MAKE LIFESTYLE CHANGES? (CIRCLE) YES NO

WHO PREPARES THE MEALS IN YOUR HOME? _____

WHO DOES THE GROCERY SHOPPING? _____

ARE YOU COMFORTABLE READING FOOD LABELS? (CIRCLE) YES NO

ARE YOU COMFORTABLE MEASURING PORTIONS? (CIRCLE) YES NO

HAVE YOU EVER KEPT A FOOD DIARY? (CIRCLE) YES NO

☐ If yes, ☐ on paper ☐ On computer ☐ On phone app ☐ Other: _____

DO YOU EAT AT A KITCHEN OR DINING ROOM TABLE? (CIRCLE) YES NO

DO YOU WATCH TV WHILE YOU EAT? (CIRCLE) YES NO

DO YOU DRINK SODA? (CIRCLE) YES NO

☐ If yes, diet or regular? _____

☐ How much soda/ day? _____

DO YOU DRINK SWEETENED BEVERAGES (IE. JUICE, ENERGY DRINKS, ICE TEA, LEMONADES)? (CIRCLE) YES NO

☐ If yes, what type and how often_____

DO YOU USE ANY ARTIFICIAL SWEETENERS? (CIRCLE) YES NO

☐ IF YES, WHICH ONES? _____

DO YOU DRINK CAFFEINE? (CIRCLE) YES NO

☐ If yes, what type and how much_____

HOW MUCH WATER DO YOU DRINK DAILY? _____

FOOD DIARY – Typical Day

****** Very important that you complete for your Initial Appointment ******

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

DO YOU EAT DESSERTS? (CIRCLE) YES NO

☐ If yes, what type? _____

☐ How often? _____

SUBSTANCE USE

DO YOU DRINK ALCOHOL? (CIRCLE) YES NO

☐ If yes, how much and how often? _____

☐ How many beverages per week? _____

DO YOU SMOKE CIGARETTES? (CIRCLE) YES NO

ARE YOU A PREVIOUS SMOKER? (CIRCLE) YES NO

☐ If yes, have you quit smoking in the past 6 months? (CIRCLE) YES NO

DO YOU HAVE ANY HISTORY OF ADDICTION? (CIRCLE) YES NO

☐ If yes, explain (including gambling/ shopping/ alcohol/ substance/ sugar, etc.)

_____

MRN:

DISORDERED EATING

DO YOU EAT FOR REASONS OTHER THAN HUNGER? (CIRCLE) YES NO

☐ If yes, explain: _____

_____

DO YOU HAVE ANY **CURRENT** DISORDERED EATING? (CIRCLE) YES NO

DO YOU HAVE ANY **PAST** ISSUES WITH DISORDERED EATING? (CIRCLE) YES NO

IF YES TO EITHER CURRENT OR PAST, PLEASE INDICATE:

☐ Anorexia ☐ Binge Eating ☐ Stress Eating ☐ Night Eating

☐ Bulimia ☐ Emotional Eating ☐ Overeating ☐ Other: _____

DO YOU HAVE ANY CRAVINGS? (CIRCLE) YES NO FOR WHAT? _____

MOOD:

DO YOU HAVE A HISTORY OF MOOD DISORDERS? (CIRCLE) YES NO . IF YES, PLEASE INDICATE:

☐ Anxiety ☐ Panic Attacks ☐ Anger ☐ Other: _____

☐ Depression ☐ Bipolar Disorder ☐ Irritability

PLEASE INDICATE YOUR LEVEL OF STRESS ON A SCALE OF 1 TO 10 (0 = NO STRESS, 10 = VERY STRESSED) :_____

SLEEP *If yes to any of these sleep questions, please complete the attached *Sleep Apnea Questionnaire*

*DO YOU HAVE ANY DIFFICULTIES WITH SLEEP? (CIRCLE) YES NO

*DO YOU SNORE? (CIRCLE) YES NO

*DO YOU STOP BREATHING AT NIGHT? (CIRCLE) YES NO

*DO YOU FEEL TIRED IN THE MORNING? (CIRCLE) YES NO

DO YOU WORK A NIGHT SHIFT OR SWING SHIFT? (CIRCLE) YES NO

HOW MANY HOURS OF SLEEP DO YOU GET? _____

HAVE YOU EVER HAD A SLEEP STUDY? (CIRCLE) YES NO

DO YOU HAVE SLEEP APNEA? (CIRCLE) YES NO

DO YOU USE A CPAP OR BIPAP MACHINE? (CIRCLE) YES NO

OCCUPATION

☐ Homemaker: _____ ☐ Retired from: _____

☐ Student: _____ ☐ On Disability: _____

☐ Occupation: _____ ☐ Other: _____

IF YOU ARE EMPLOYED, HOW MANY HOURS PER WEEK DO YOU WORK? _____

DO YOU FEEL THAT YOUR JOB IS STRESSFUL? (CIRCLE) YES NO

EXERCISE and ACTIVITY

PLEASE INDICATE THE LEVEL OF ACTIVITY THAT YOUR JOB REQUIRES:

☐ Sedentary ☐ Moderate Activity

☐ Light Activity ☐ Heavy Labor

DO YOU EXERCISE? (CIRCLE) YES NO

☐ If yes, how many days per week? _____

☐ What do you do for exercise? _____

☐ How long have you been exercising regularly? _____

IF YOU EXERCISE, PLEASE INDICATE THE INTENSITY OF YOUR EXERCISE

☐ Light (you could sing) ☐ Vigorous (you are only able speak a few words)

☐ Moderate (you can speak in complete sentences) ☐ Intervals of moderate and vigorous

WHAT EXERCISES TO YOU ENJOY? _____

DO YOU HAVE ANY LIMITATIONS TO EXERCISE?

☐ Injury ☐ Health ☐ Time

☐ Motivation ☐ Access

MRN:

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: (CHECK ALL THAT APPLY)

- ☐ **HEART DISEASE** (heart attack, bypass surgery, stents, angioplasty, coronary disease, sudden death, cardiomyopathy)
  - Was it at a premature age (women under age 65, men under age 55? (CIRCLE) YES NO
- ☐ **DIABETES**
- ☐ **HYPOTHYROID**
- ☐ **SLEEP APNEA**
- ☐ **WEIGHT PROBLEMS**
- ☐ **CANCER**

HAVE YOU EVER HAD AN EKG? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

HAVE YOU EVER HAD A STRESS TEST? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

HAVE YOU EVER HAD AN ECHOCARDIOGRAM? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

Thank you for taking the time to complete this questionnaire. This information will help us prepare for your initial appointment.

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