

Dear Interested Patient,

I'd like to personally welcome you to our practice and congratulate you on taking this step to improve your health. Our program is a comprehensive, individualized journey and will require a lot of work by all of us. In an effort to streamline the initial visit, it is very helpful if you complete the intake paperwork, which includes:

- Medical Release Form
- Patient Demographics/Program Questionnaire Healthy Weight Obstacle
- Binge Eating Disorder
- Smart Goal setting
- Food Journal for 1- 2 weeks
- Sleep Questionnaire

I understand it is a lot of preparation for an initial consultation, but without the information, there is typically a 2-4 week delay in starting the program.

In addition, please bring copies of any recent laboratory results, EKG, stress test or records you believe would be helpful for us to review. There is a medical release form you can send to any physician who may have information that will be valuable to our consultation.

When you arrive for your initial visit, you can expect to be escorted to an examination room where a Medical Assistant will check your blood pressure, height, weight, body fat and waist measurement. I will then review your paperwork and join you in the room to perform a history and physical exam. Depending upon this exam, we will determine if additional labs or tests would be beneficial. If you are not fasting, you may need to return for the blood work. You can anticipate spending 1-2 hours here for the initial visit. If we have everything needed to get you started, we will try to do so at that visit. Together, we will develop a plan that includes, nutrition, exercise, behavioral modification and, perhaps, medication. After the first visit, you will meet with me every 2-4 weeks and our Nutritional Counselor every 2-4 weeks.

Although we will bill your insurance company, we cannot guarantee they will pay for any or all the services. As with all of your medical care, you will be responsible for your co-pay at time of service, any deductibles you may have, and cost of medications, supplements and vitamins. Should you elect to pay out of pocket, we do offer a package through MD Save (see packet for additional information). Our main priority is to help you reach your goals in the most enjoyable and cost effective manner. I look forward to meeting with you.

Sincerely,

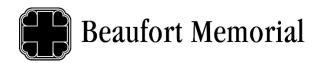
Yvette-Marie Pellegrino MD, FAAFP, ABOM



Program Questionnaire

Please complete this questionnaire and bring it with you to your appointment with the doctor. This information will assist us in your care plan. Thank you.

Full Name:		Date o	fBirth:
Personal Information Gender: □ Female □ N Address:			
Address 2 (apt., unit, su	ite, etc.):		
			Phone:
Race (please check all the African-American		□ Hispanic	□ Pacific Islander/Hawaiian
□ Asian □ Other			
How did you hear about □ Newspaper □ Bro □ BMH Employee □ Otl	chure 🗆 Friend		cian
Check all that apply I am interested in medica uvia diet, exercise, pres	ally supervised weig criptions	ht loss:	
□ balloon insertion or su	rgery with litestyle c	ounseling on nut	rition and exercise



Insurance Information

We may use your insurance to get medications or procedures covered, if deemed medically necessary. Please note, not all insurance policies provide coverage for weight loss/obesity treatment.

1. Insurance Company:	State:
Delian muscham	
Group number:	<u> </u>
2. Insurance Company:	State:
Policy holder's name:	
Policy holder's date of birth:	
Policy number:	
Group number:	
Insurance company phone:	
3. Insurance Company:	State:
-Policy holder's name:	
Policy holder's date of birth:	
Policy number:	
Group number:	
Insurance company phone:	



Physician Info	rmation				
Primary Care/Family	Physician:				
Practice Name:					
Address:					
Address 2:					
City, State, Zip:					
Office phone:					
Referring Physician (if different from abo					
Specialty:					
Practice name:					
Address:					
City, State, Zip:					
Office phone:					
Do you regularly se	ek treatment	from a phy	sician or other provide	r in any of these areas?	
(Check all that appl	y.)				
□ cardiologist	□ chiropra	ctor	□ endoscopic	□ gastrointestinal	
□ general surgery	□ hematol	ogist	□ infectious disease	□ neurologist	
□ orthopedic	□ pain maı	nagement	□ physical therapist	□ psychiatrist	
□ pulmonologist					



Weight History

Current weight:		lbs Curre	ent height: in	
BMI (body mass				
Number of years	•			
Highest adult we	eight:	When?:		
Lowest adult we	ight:	When?:		
As best you can	recall, what was your body we	eight at each of tl	he following points of your life?	
Grade school 40-49 lbs	lbs High school s 50-59 lbs			lbs
What is the most	t weight you lost?	lbs		
When did you lo	sethisweight?			
How long did yo	u keep this weight off?			
Method used for	rthis weight loss:			
Medical Histor	v			
Have you ever ha	-			
Cancer	au. □ No □ Yes	Reflux	□ No □ Yes	
_	cer:	Seizures		
Diabetes	□ No □ Yes	Sleep Apnea		
Heart attack	□ No □ Yes	Stroke		
Hepatitis	□ No □Yes	Transfusions	□ No □ Yes	
High cholesterol	□ No □ Yes	Ulcers	□ No □Yes	
Hypertension	□ No □ Yes	Other diagnose:	S	_
Lung disease	□ No □ Yes			
Previous Opera	tions			
Have you had baria	atric surgery? □ No □ Yes			
If yes, year, surgeo	on and location of surgery:			
Did you have comp	olications from surgery? □ No	□ Yes		
Gallbladder	□ No □ Yes			
Joint	□ No □ Yes			
Hernia	□ No □Yes			
Other Operations	s:			

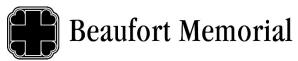


Medications and Supplements

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	



Current Medical Conditions

General											
Fever	□ No	□ Ye	s	Ir	nsomnia	□ No □	□ Yes				
Fatigue	□ No	□ Ye	s	S	Stress	□ No □	∃Yes				
Recent weight change	□ No	□ Ye	s								
Comments?											
ENT											
Eye/vision problems	□ No	□ Yes	6	F	requent c	olds		□ No □ Y	'es		
Hearing loss/ringing	□ No	□ Yes	3	С	ental prob	olems		□ No □ `	⁄es		
Ear aches	□ No	□ Yes	6	S	ore throat	/hoarsene	ss	□ No □ `	⁄es		
Nose bleeds	□ No	□ Yes	6	S	Swollen gla	ands		□ No □ Y	'es		
Sinus problems	□ No	□ Yes	3								
Comments?											
Cardiac											
Chest pain		No		Yes	Irregula	r/fast heartl	beat (aı	rhythmia)		No	Yes
High blood pressure		No		Yes	CHF (he	eart failure)	1			No	Yes
(hypertension)											
MI (Myocardial infarction)		No		Yes	Valvular	/heart dise	ase			No	Yes
Comments?											
Pulmonary											
_	□ No □	∃ Yes			Chronic b	oronchitis	□ No	o □ Yes			
Shortness of breath					Asthma		□ No	yes			
	□ No [□Yes									
Comments?											
Vascular											
Varicose Veins	[□ No	□Y	es							
Phlebitis	[□ No	□Y	es							
Swelling	[□ No	□Y	es Loc	ation:						
Diagnosis of lymphedem	na	□ No	□Y	es Loc	cation:			<u></u>			
Cellulitis (skin infection)		□ No	□Y	es Loc	cation:			_			
Comments?											
Bleeding disorders											
Slow to heal after cuts		□ No □] Ye	s							
Commented											



Current Medical Conditions (continued)

Gastrointestinal

Loss of Appetite			No)		Υe	es l	nflamm	atory bowel	diseas	е	No		Yes
Nausea/Vomiting			No)		Υe	es (Colitis				No		Yes
Throwing up Blood			No)		Υe	es (Crohn's	Disease			No		Yes
Blood in stool			No)		Υe	es l	Hemorr	hoids			No		Yes
Constipation			No)		Υє	es l	_iver dis	sease			No		Yes
Gall bladder problems/sto	nes		No)		Υe	es l	rritable	bowel syndro	ome		No		Yes
Peptic ulcer disease			No)		Υe	es F	Reflux S	Symptoms (h	eartbu	rn)	No		Yes
Number of bowel movements?		•	•											
Musculoskeletal														
Joint Pain				No			Yes	Arth	nritis		No	Υε	es	
Muscle/joint weakness				No			Yes	Bac	k Pain		No	Υε	es	
Pain when walking				No			Yes	Col	d extremities		No	Υe	es	
Numbness or tingling in a	rms	/legs		No			Yes							
Comments?														
Neurologic														
Frequent headaches		No		Y	es		Se	izures			No	_ ,	Yes	
Light headed/dizzy		No		Y	es		Pa	ıralysis			No		Yes	
History of falling		No		Y	es		Hi	story of	stroke or TIA	٦ ۔	No	□ ,	Yes	
Comments?														
Diabetes, Endocrine														
Diabetes Type 1 or 2 (with	h me	edicati	ons)			No		Yes	Heat/cold i	ntolera	ance	No		Yes
Pre-diabetic]	No		Yes	Thyroid pro	blems	5	No		Yes
History of gestational diab	etes	3]	No		Yes	Hypglycem	nia		No		Yes
Excessive thirst or urination	on					No		Yes						
Comments?														



Current Medical Conditions (continued)

Skin				
) □ Yes □) □ Yes □	Change in skin/hair/na Latex allergy		Yes □
Comments?				
Psychological				
Memory loss/confusion		Schizophrenia	No □ Ye	
Anxiety	No □ Yes □	Hallucinations	No □ Ye	
Nervousness	No □ Yes □	Suicide attempts	No □ Ye	
Depression	No □ Yes □	Homicidal thoughts	No □ Ye	
Bipolar disorder	No □ Yes □	Alcohol abuse	No □ Ye	
Personality disorder	No □ Yes □	Substance abuse	No □ Ye	S 🗆
Have you ever been in o	ounseling?	No □ Yes □		
Psychological hospitaliz	ations	No □ Yes □		
Eating disorder: bulimia	anorexia nervosa	No □ Yes □		
Have you ever received (short-term or long-term	•	No □ Yes □		
Are you currently on or a	applying for disability	y? No □ Yes □		
Is all or part of your disato a psychological, psycor cognitive issue?	•	No □ Yes □		
What conditions(s), disor	ders(s), diagnosis, o	rdisease(s) led to yourd	disability?_	
Genitourinary				
Frequent urination	No □ Yes □	☐ Kidney stones		No □ Yes □
Painful/burning urination Bladder control problem (stress incontinence)		Change in force or	stream	No □ Yes □
Comments?				
Males Only				
Testicle Pain No □ Yes	s □ Prosta	ate Problems No □ Y	es □	
Comments?				
Females Only Last M	ammogram			
Breast Pain	No □ Yes □	Breast lump		No □ Yes □
Nipple discharge/bleedir		Family history of bro	east cance	er No □ Yes □
Comments?				



Current Medical Conditions (continued)

What is your exercise routine?

Last pap smear				-NV
Age at first menstru			iinful/irregular periods	
Menstrual frequenc	:y	La	stmenstrual period_	
Age at first pregnar	ncy			
Number of pregnancie	es	Ful	ll-term Miscai	rriages
Did you breast feed	? □ No I	□Yes		
Infertility	□ No	□Yes or in the p	past	
Plans for future pre	gnancy □ No i	□ Yes If so, whe	en:	
Comments?				
Family History				
Family History Overweight family r	members			
Family history of hea				
Family history of dia	betes/endocri	ne disease		
Family history of hig	gh blood pressi	ure		
Family history of car	ncer			
Family history of art	thritis			
Family history of ea	rly death	_		
Family history of as	thma			
Family history of str	oke			
Family historyof de	pression			
Other family disease	e history			
Social History				
Employment status	□ Full Time	□ Part Time	□ Self Employed	☐ Homemaker
	□ Student	□ Retired	□ Disabled	□ Unemployed
Employer			Occupation	
Marital Status	☐ Single	☐ Married	☐ Separated	
	☐ Divorced	☐ Widowed	□ Partnered	
Children				
			Illed	al Druguse?
Tobacco use?	<i>F</i>	1001101 430 :		, <u></u>

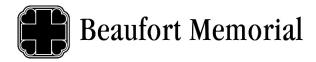


Healthy Weight Obstacles

To help us plan the best diet for your, please answer the following questions.

Do any of the following environmental issues listed below affect your weight? If so, please explain.

1. (Occupation-related eating issues: □ No □ Yes								
2. 7	Travel: □No □ Yes								
3. H	Household issues (family/obligations/schedule) □ No □Yes								
	Shopping/cooking/etc: □ No □ Yes Who does the food shopping?								
6. N	Financial issues No Yes Meals eaten away from home (frequency/location): No Yes Sleep No Yes								
Do a	any of the following eating behaviors listed below affect your weight? If so, please explain.								
□Niọ	ight Eating Disorder (Eating very late at night, waking up in the middle of the night to eat.) Current Problem □ No □ Yes Past Problem □ No □ Yes								
□Er	motional Eating								
C	Current Problem No Yes								
P	Past Problem □ No □ Yes								
	Frequent Cravings Current Problem No Yes								
	Past Problem □ No □ Yes								
□Lac	ck of awareness of hunger								
C	Current Problem □ No □ Yes								
P	Past Problem □ No □ Yes								
_ L	Lack of awareness of fullness								
C	Current Problem D No D Yes								
Р	Past Problem D No D Yes								



Binge Eating

The following questions ask about your eating problems and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

A. 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

NOTE: If you answered no to the above question, you may continue to the next page.

The questions below do not apply to you.

B. Do you feel distressed about your episodes of excessive overeating? YES NO

Within the past 3 months ...

		Never or Rarely	Sometimes	Often	Always
C.	During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
D.	During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
E.	During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
F.	During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				



Please answer the questions below to the best of your ability: Attach additional sheets if needed.

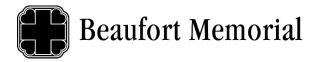
1.	Do you have any food allergies? No Yes If yes, what are they?										
2.	Do you have any food intolerances? □No □ Yes If yes, what are they?										
3.	What would you like to achieve from visiting with the dietitian?										
4.	Do you see any barriers to achieving this goal? □No □ Yes If yes, what are they?										
5.	How often do you eat fast food?Where?										
	What do you typically eat when you order fast food?										
6.	How often do you eat at restaurants? What do you typically eat when you order from a restaurant?										
7.	How often do you eat fried foods? What fried foods do you typically eat?										
8.	. How often do you eat sweets?										
9.	Check the box if you use: Butter Margarine Salad Dressing Oil Mayonnaise Ketchup Marinades Sauces Gravy										
10.	Check the box if you drink: Regular Soda Diet Soda Water Juice Juice Drink Coffee Tea Energy Drinks Milk Other:										
11.	Do you consume alcoholic beverages? No Yes If yes, what type? If yes, how often?										
12.	What types of food do you crave?										
13.	Do you eat fruits and vegetables daily? □ No □ Yes What types of fruits and vegetables do you eat?										
	Place a check in the box if you eat daily and whattype: Cheese □ Regular full fat □ 2% reduced fat □ 1% low fat □ 0%skim/fat-free Yogurt □ Regular full fat □ 2% reduced fat □ 1% low fat □ 0%skim/fat-free Milk □ Regular full fat □ 2% reduced fat □ 1% low fat □ skim/fat free										
15.	.Check all that you eat: □ Meat □ Poultry □ Beans □ Tofu □ Nuts □ Eggs										



Diet History

Have you tried popular diets or sought help to lose weight in the past? If so, please share as much detail as you can.

Program	Weight Lost	Weight Regained	Month /Year	How long were you on the program?	Why did you stop?
Weight Watchers					
Overeaters Anonymous					
Jenny Craig, Nutrisystem, LA Weight Loss, The Diet Center, etc.					
OTC diet pills					
Counseling : specify: RD, psychologist, etc.					
Prescription weight loss meds (Fen Phen, phentermine, Redux, Meredia, Xenical, etc.)					
Weight Loss Injections					
Hypnosis					
Exercise					
Low Carb Diets, specify plan:					
Physician Sponsored Diets					
Diet books, fad diets					
Liquid diets: Medifast, Slimfast, Optifast, etc.					



Setting SMART Goals:

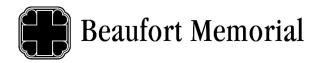
SMART goals are Specific, Measurable, Attainable, Relevant and Time Based. As part of our program we strive to help you achieve short term goals and prepare you to be able to achieve your long term goals.

Please take some time and decide upon at least 3 short-term goals (3-12 months) and 3 long-term goals (1 + years). Bring this list to your next office visit so we can review and help you develop a plan to reach them.

Here is sample template.

GOAL In as few words as possible, write down what you want to achieve.	
SPECIFIC Now add some details (who, what, where, how, when).	
MEASURABLE How will you know when you reached your goal?	
ATTAINABLE What else will you need to reach this goal?	
RELEVANT Why you want to reach your goal.	
TIMELY Set some benchmarks and deadline.	

Your goals do not have to revolve around your weight. They can be anything at all! You will succeed if you believe it is achievable, develop a plan, and have the resources in place.



Sleep Questionnaire

Have you been told you snore?		No		Yes				
Are you often tired during the day?		No		Yes				
Do you know if you stop breathing?		No		Yes				
Do you have high blood pressure or are you on		No		Yes				
medication to control high blood pressure?								
Is your body mass index >28?		No		Yes				
Are you 50 years old or older?		No		Yes				
Are you a male with a neck circumference >17"		No		Yes				
or a female with a neck circumference >16"								
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation. 0 = would never fall asleep 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing								
Sitting and reading Watching TV Sitting in a public place (i.e. theatre, meeting) As a passenger in a car for an hour without a break Lying down to rest in the afternoon Sitting and talking to someone Sitting quietly after a lunch w/o alcohol In a care while stopped for a few minutes in traffic								
Total								