Beaufort Memorial

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

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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 of Birth:**_____

Personal Information

Gender: □ Female □ Male

Address: _____

Address 2 (apt., unit, suite, etc.):_____

City, State, Zip:_____

Email:_____ Daytime Phone:_____

Race (please check all that apply):

□ African-American □ Caucasian □ Hispanic □ Pacific Islander/Hawaiian

□ Asian □ Native American

□ Other _____

How did you hear about our program?

□ Newspaper □ Brochure □ Friend □ My physician

□ BMH Employee □ Other _____

Check all that apply

I am interested in medically supervised weight loss:

□ via diet, exercise, prescriptions

□ balloon insertion or surgery with lifestyle counseling on nutrition and exercise

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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: ____

Policy holder's name: _____

Policy holder's date of birth: _____

Policy number: _____

Group number: _____

Insurance company phone: _____

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: _____

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Physician Information

Primary Care/Family Physician: _____

Practice Name: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Office phone: _____

Referring Physician: _____
(if different from above.)

Specialty: _____

Practice name: _____

Address: _____

City, State, Zip: _____

Office phone: _____

Do you regularly seek treatment from a physician or other provider in any of these areas?

(Check all that apply.)

☐ cardiologist	☐ chiropractor	☐ endoscopic	☐ gastrointestinal
☐ general surgery	☐ hematologist	☐ infectious disease	☐ neurologist
☐ orthopedic	☐ pain management	☐ physical therapist	☐ psychiatrist
☐ pulmonologist			

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Weight History

Current weight: _____ lbs Current height:_____in

BMI (body mass index): _____

Number of years overweight: _____

Highest adult weight: _____When?:_____

Lowest adult weight: _____When?:_____

As best you can recall, what was your body weight at each of the following points of your life?

Grade school ____ lbs High school ____ lbs Ages 20-29____ lbs 30-39 ____ lbs
40-49___ lbs 50-59___ lbs 60-69____ lbs

What is the most weight you lost?_____lbs

When did you lose this weight?_____

How long did you keep this weight off?_____

Method used for this weight loss:_____

Comments? _____

_____

Medical History

Have you ever had:

Cancer ☐ No ☐ Yes
If yes, type of cancer: _____
Diabetes ☐ No ☐ Yes
Heart attack ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes
High cholesterol ☐ No ☐ Yes
Hypertension ☐ No ☐ Yes
Lung disease ☐ No ☐ Yes
Reflux ☐ No ☐ Yes
Seizures ☐ No ☐ Yes
Sleep Apnea ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
Transfusions ☐ No ☐ Yes
Ulcers ☐ No ☐ Yes
Other diagnoses _____
_____

Previous Operations

Have you had bariatric surgery? ☐ No ☐ Yes
If yes, year, surgeon and location of surgery: _____
Did you have complications from surgery? ☐ No ☐ Yes
Gallbladder ☐ No ☐ Yes
Joint ☐ No ☐ Yes
Hernia ☐ No ☐ Yes

Other Operations:_____

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Medications and Supplements

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	

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Current Medical Conditions

General

Fever	☐ No ☐ Yes	Insomnia	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes	Stress	☐ No ☐ Yes
Recent weight change	☐ No ☐ Yes		

Comments? _____

ENT

Eye/vision problems	☐ No ☐ Yes	Frequent colds	☐ No ☐ Yes
Hearing loss/ringing	☐ No ☐ Yes	Dental problems	☐ No ☐ Yes
Ear aches	☐ No ☐ Yes	Sore throat/hoarseness	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes	Swollen glands	☐ No ☐ Yes
Sinus problems	☐ No ☐ Yes		

Comments? _____

Cardiac

Chest pain	☐ No ☐ Yes	Irregular/fast heartbeat (arrhythmia)	☐ No ☐ Yes
High blood pressure (hypertension)	☐ No ☐ Yes	CHF (heart failure)	☐ No ☐ Yes
MI (Myocardial infarction)	☐ No ☐ Yes	Valvular/heart disease	☐ No ☐ Yes

Comments? _____

Pulmonary

Sleep apnea	☐ No ☐ Yes	Chronic bronchitis	☐ No ☐ Yes
Shortness of breath with 1 flight of stairs	☐ No ☐ Yes	Asthma	☐ No ☐ Yes

Comments? _____

Vascular

Varicose Veins	☐ No ☐ Yes
Phlebitis	☐ No ☐ Yes
Swelling	☐ No ☐ Yes Location:
Diagnosis of lymphedema	☐ No ☐ Yes Location: _____
Cellulitis (skin infection)	☐ No ☐ Yes Location: _____

Comments? _____

Bleeding disorders

Slow to heal after cuts ☐ No ☐ Yes

Comments? _____

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Current Medical Conditions (continued)

Gastrointestinal

Loss of Appetite	☐ No	☐ Yes		Inflammatory bowel disease	☐ No	☐ Yes	
Nausea/Vomiting	☐ No	☐ Yes		Colitis	☐ No	☐ Yes	
Throwing up Blood	☐ No	☐ Yes		Crohn's Disease	☐ No	☐ Yes	
Blood in stool	☐ No	☐ Yes		Hemorrhoids	☐ No	☐ Yes	
Constipation	☐ No	☐ Yes		Liver disease	☐ No	☐ Yes	
Gall bladder problems/stones	☐ No	☐ Yes		Irritable bowel syndrome	☐ No	☐ Yes	
Peptic ulcer disease	☐ No	☐ Yes		Reflux Symptoms (heartburn)	☐ No	☐ Yes	

Number of bowel movements per day:___

Comments?_____

Musculoskeletal

Joint Pain	☐ No	☐ Yes		Arthritis	☐ No	☐ Yes	
Muscle/joint weakness	☐ No	☐ Yes		Back Pain	☐ No	☐ Yes	
Pain when walking	☐ No	☐ Yes		Cold extremities	☐ No	☐ Yes	
Numbness or tingling in arms/legs	☐ No	☐ Yes					

Comments? _____

Neurologic

Frequent headaches	☐ No	☐ Yes		Seizures	☐ No	☐ Yes	
Light headed/dizzy	☐ No	☐ Yes		Paralysis	☐ No	☐ Yes	
History of falling	☐ No	☐ Yes		History of stroke or TIA	☐ No	☐ Yes	

Comments? _____

Diabetes, Endocrine

Diabetes Type 1 or 2 (with medications)	☐ No	☐ Yes		Heat/cold intolerance	☐ No	☐ Yes	
Pre-diabetic	☐ No	☐ Yes		Thyroid problems	☐ No	☐ Yes	
History of gestational diabetes	☐ No	☐ Yes		Hypglycemia	☐ No	☐ Yes	
Excessive thirst or urination	☐ No	☐ Yes					

Comments?_____

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Current Medical Conditions (continued)

Skin

Rash/itching No ☐ Yes ☐ Change in skin/hair/nails No ☐ Yes ☐
Bleeding/bruising No ☐ Yes ☐ Latex allergy No ☐ Yes ☐

Comments? _____

Psychological

Memory loss/confusion	No ☐ Yes ☐	Schizophrenia	No ☐ Yes ☐
Anxiety	No ☐ Yes ☐	Hallucinations	No ☐ Yes ☐
Nervousness	No ☐ Yes ☐	Suicide attempts	No ☐ Yes ☐
Depression	No ☐ Yes ☐	Homicidal thoughts	No ☐ Yes ☐
Bipolar disorder	No ☐ Yes ☐	Alcohol abuse	No ☐ Yes ☐
Personality disorder	No ☐ Yes ☐	Substance abuse	No ☐ Yes ☐

Have you ever been in counseling? No ☐ Yes ☐

Psychological hospitalizations No ☐ Yes ☐

Eating disorder: bulimia/anorexia nervosa No ☐ Yes ☐

Have you ever received disability benefits (short-term or long-term) for any reason? No ☐ Yes ☐

Are you currently on or applying for disability? No ☐ Yes ☐

Is all or part of your disability status related to a psychological, psychiatric, emotional or cognitive issue? No ☐ Yes ☐

What conditions(s), disorders(s), diagnosis, or disease(s) led to your disability?_____

_____

Genitourinary

Frequent urination No ☐ Yes ☐ Kidney stones No ☐ Yes ☐
Painful/burning urination No ☐ Yes ☐ Change in force or stream No ☐ Yes ☐
Bladder control problems (stress incontinence) No ☐ Yes ☐

Comments? _____

Males Only

Testicle Pain No ☐ Yes ☐ Prostate Problems No ☐ Yes ☐

Comments?_____

Females Only

Last Mammogram _____

Breast Pain No ☐ Yes ☐ Breast lump No ☐ Yes ☐
Nipple discharge/bleeding No ☐ Yes ☐ Family history of breast cancer No ☐ Yes ☐

Comments? _____

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Current Medical Conditions (continued)

Females Only

Last pap smear_____

Age at first menstrual period _____ Painful/irregular periods ☐No ☐Yes

Menstrual frequency _____ Last menstrual period_____

Age at first pregnancy_____

Number of pregnancies _____ Full-term ___ Miscarriages___

Did you breast feed? ☐ No ☐ Yes

Infertility ☐ No ☐ Yes or in the past

Plans for future pregnancy ☐ No ☐ Yes If so, when:_____

Comments? _____

Family History

Overweight family members _____

Family history of heart disease _____

Family history of diabetes/endocrine disease _____

Family history of high blood pressure _____

Family history of cancer _____

Family history of arthritis _____

Family history of early death _____

Family history of asthma _____

Family history of stroke _____

Family history of depression _____

Other family disease 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 _____

Tobacco use?_____ Alcohol use?_____ Illegal Druguse? _____

Comments? _____

Activity/Exercise

Do you exercise regularly? ☐ No ☐ Yes

What is your exercise routine?

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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. Travel: ☐No ☐ Yes _____
3. Household issues (family/obligations/schedule) ☐ No ☐Yes_____
4. Shopping/cooking/etc: ☐ No ☐ Yes_____
   Who does the food shopping? _____
5. Financial issues ☐ No ☐ Yes _____
6. Meals eaten away from home (frequency/location): ☐ No ☐ Yes
7. Sleep ☐ No ☐Yes

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

☐**Night 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 _____

☐**Emotional Eating**
Current Problem ☐ No ☐ Yes _____
Past Problem ☐ No ☐ Yes _____

☐ **Frequent Cravings**
Current Problem ☐ No ☐ Yes _____
Past Problem ☐ No ☐ Yes _____

☐**Lack of awareness of hunger**
Current Problem ☐ No ☐ Yes _____
Past Problem ☐ No ☐ Yes _____

☐ **Lack of awareness of fullness**
Current Problem ☐ No ☐ Yes_____
Past Problem ☐ No ☐ Yes_____

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Binge Eating

The following questions ask about your eating problems and behaviors within the last 3 months. For each question, choose the answer 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?	☐	☐	☐	☐

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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?_____
What sweets do you typically eat?_____

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
□ Iced Tea □ 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? _____

14. Place a check in the box if you eat daily and what type:
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

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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.					

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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.

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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 medication to control high blood pressure?	□ No	□ Yes

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" or a female with a neck circumference >16"	□ No	□ Yes

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	___