

Weight Management



PETER LING ACUPUNCTURE

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>last, First, M.I.</i>):		<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:	
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PERSONAL HEALTH HISTORY

To the best of your knowledge, how would you rate your health?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Present Weight (lbs):	Height (inches)	Desired Weight:		
In what time frame would you like to be at your desire weight?				
What is the main reason for your decision to lose weight?				

Does your family support your efforts to lose weight?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you overweight or obese?				<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you suffer from any of these health conditions?	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hypothyroid
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> COPD	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Heart disease (Heart attack or chest pain)	<input type="checkbox"/> Arthritis (Joint Pains)	

List any medical problems that other doctors have diagnosed

Surgeries (Year and Reason)

Other hospitalizations

List your current prescribed drugs and over-the-counter drugs, such as vitamins and supplements		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications

HEALTH HABITS & LIFESTYLE

Exercise	<input type="checkbox"/> Sedentary (little or no exercise)		
	<input type="checkbox"/> Lightly active (light exercise/sports 1-3 days/week)		
	<input type="checkbox"/> Moderately active (moderate exercise/sports 3-5 days/week)		
	<input type="checkbox"/> Very active (hard exercise/sports 6-7 days a week)		
	<input type="checkbox"/> Extra active (very hard exercise/sports & physical job or 2x training)		
Diet	Are u dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day? <input style="width: 50px;" type="text"/>	How often do you eat out? <input type="checkbox"/> Never <input type="checkbox"/> Less Often <input type="checkbox"/> Frequently	
	What restaurants do you frequently eat out?	How often do you eat "fast foods?" <input type="checkbox"/> Never <input type="checkbox"/> Less Often <input type="checkbox"/> Frequently	
	What time of day and on what day do you shop for groceries?		
	Rank fat intake	<input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	How many times per weeks?	
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	What kind of tobacco (Cigarette, Chew, Pipe, Cigars)?	How many per day?	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No

DIETARY HISTORY

1. Record all weight loss attempts starting with your first diet through your most recent attempt.
2. If you have tried weight-loss medications also, include the type of diet plan you followed (e.g. Low fat, 1200 calorie, etc.) while receiving medication.

Year	How long were you on this diet?	Weight at start of this diet	Weight lost on this diet	Type of Diet/Weight Loss Program If any Weight Loss Med Used	Doctor or Dietician who supervised this diet

Supervised Diets <ul style="list-style-type: none"> ▪ Diet Counters ▪ Medfast ▪ Supervised calories counting diet (Dietician or Nutritionist) ▪ Overeaters Anonymous ▪ Optifast ▪ New Direction ▪ Weight Watchers ▪ Health Management Resources ▪ Nutri-Systems ▪ T.O.P.S ▪ Jenny Craiq ▪ National Weight Loss 	Non-Supervised Diets <ul style="list-style-type: none"> ▪ Body for life ▪ Calorie counting ▪ Atkins Diet ▪ Health Spas ▪ High Protein ▪ Hypnosis ▪ Low carbohydrates ▪ Low fat ▪ Pritikin ▪ Richard Simmons ▪ Scardale ▪ Stillman Diet ▪ Sugar Busters ▪ Slim-Fast ▪ Mayo Clinic 	Weight Loss Medications <ul style="list-style-type: none"> ▪ Acutrim ▪ Adipex-P ▪ Amphetamines ▪ Anorex ▪ Benzphetamine ▪ Bontril ▪ Dexatrim ▪ Dexfenfluramine ▪ Didrex ▪ Fastin ▪ Fenfluramine ▪ Fen-Phen ▪ Ionamin ▪ Mazanor ▪ medridia
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MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WOMEN ONLY

First Day of last menstruation:	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Review of Body Systems In the last 6 months, have you experienced any of the following symptoms?

Constitutional		Genitourinary	
Weight Loss or Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in your urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appetite changes (increased or decreased)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual changes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue, profound & impairs daily function	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinating that is painful or difficult	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erection problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shakes/sweats from lack of alcohol or drug	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal discharge or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes		Musculoskeletal	
Eye pain or drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry, irritated eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No
ENT/Mouth		Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain or drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent sinus infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin/Breast	
Hearing changes or loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Masses or lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nosebleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nipple discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes or nonhealing ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory		Neurologic	
Blood in your sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coughing or choking with swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough lasting > 1 month, productive or not	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive daytime sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extremity pain or burning sensations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain with inhalation or coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular		Difficulty falling asleep, staying asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrinologic	
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or near fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of feet or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath lying flat in bed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat or cold intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal		Heme/Lymph	
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding from gums or nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in your stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea or Food intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen, painful lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy/Immun	
Vomiting or nausea lasting for > 1 day	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watery eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swallowing difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psych		Food intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety without clear explanation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent skin sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sadness lasting for days or weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing voices	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Thoughts of hurting yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Thought of hurting others	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fear of people, places or things	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No