PROGRAM Preference: ☐ VLCD ☐ LCD ☐ Phase 2
☐ DPP/Healthy Lifestyle ☐ Nutrition Counseling

SITE: ☐ Kirmayer ☐ Lawrence ☐ Medwest

The University of Kansas Weight Management Programs

_____ _____
Last Name First Name Today's Date

_____
Address City State Zip Code

Age: _____ Date of Birth: _____ Gender: M F Sex: M F

Which of the following would you say best represents your race?

_____ White _____ Native Hawaiian / Pacific Islander _____ Multiracial

_____ Black or African American _____ Native American / Alaska Native

_____ Asian _____ Other / Unknown

Which of the following would you say best represents your ethnicity?

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Other or Unknown

The above information is collected for aggregate descriptive purposes only

Preferred Phone: ( )_____ Email: _____

WEIGHT HISTORY

Current Weight _____ Height _____ Lowest Adult Weight _____ Highest Adult Weight _____

Previous weight reduction attempts/methods: _____

_____

Have you ever taken any prescription weight loss medications? If yes, what and when? _____

_____

Physical Activity

Do you have any physical restrictions to activity? ☐yes ☐no Explain: _____

_____

MEDICAL HISTORY

Do you have or have you ever had any of the following medical conditions?

			Date/Year of Diagnosis	Describe the Problem
High Cholesterol	☐yes	☐no	_____	_____
Kidney Problems	☐yes	☐no	_____	_____

Liver Problems	☐yes	☐no	_____	_____
Psychiatric Problems	☐yes	☐no	_____	_____
Sleep Apnea	☐yes	☐no	_____	_____

Have you had any surgery in the past 12 months? ☐yes ☐no

If yes, please describe the surgery:_____

_____

Allergies

Have you ever had a reaction to:			If yes, please explain reaction:
Milk/Dairy products	Y	N	_____
Eggs	Y	N	_____
Soy products	Y	N	_____
Corn products	Y	N	_____
Wheat gluten	Y	N	_____
Other food	Y	N	_____

Reproductive (WOMEN ONLY)

Are you currently pregnant? ☐yes ☐no

Were you pregnant within the past 6 months? ☐yes ☐no

Do you plan to become pregnant in the next 18 months? ☐yes ☐no

Are you currently breast feeding? ☐yes ☐no

DIABETES HISTORY (If applicable)

Diabetes Onset

Year of Diagnosis: _____ Most Recent Hgb A1c level: _____ Date Taken: _____

Current Managing Physician: _____

Address: _____ Phone #: _____

Blood Sugars

Do you currently perform home blood sugar checks? ☐ No ☐ Yes

If so, how often? _____ Recent levels: _____

Have you ever experienced hypoglycemia (low blood sugar): ☐ No (skip 1-3) ☐ Yes (answer below)

1) What are your personal signs and symptoms of hypoglycemia? _____

_____

2) What has been your usual treatment for hypoglycemia? _____

_____

3) Do you have hypoglycemia without warning symptoms? ☐ No ☐ Yes

Diabetes Complications

Has your diabetes ever resulted in hospitalization, diabetic coma or DKA/ketoacidosis?

☐ No ☐ Yes _____

The University of Kansas Physicians

3901 Rainbow Blvd. Kansas City, KS 66160

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name:_____
KUMC#:_____
Date:_____ **DOB:**_____

Primary Care Doctor_____ **Phone(____)** _____ **Address**_____
Referring Doctor_____ **Phone(____)** _____ **Address**_____

Reason for Visit:

Medical History:

- **Patient medical history:**

			Previous Hospitalizations/Surgeries/Serious Injuries	**When?**
Diabetes	Yes	No		
Hypertension	Yes	No		
Cancer	Yes	No		
Stroke	Yes	No		
Heart trouble	Yes	No		
Arthritis/gout	Yes	No	**Medications:**	
Convulsions	Yes	No		
Bleeding tendency	Yes	No		
Acute infections	Yes	No		
Sexual disease	Yes	No		
Birth defects	Yes	No		
Thyroid problems	Yes	No		
Osteoporosis	Yes	No		
Vision problems	Yes	No	**Allergies:**	
Hearing problems	Yes	No		
Ulcer/stomach problems	Yes	No		
Back pain	Yes	No		

Other: _____

_____

- **Patient social history:**

Marital status: Single:_____ Married:_____ Separated:____ Divorced:____ Widowed:_____
Use of alcohol: Never:_____ Rarely:_____ Moderate:____ Daily:_____
Use of tobacco: Never:_____ Previously, but quit:_____ Current packs /day:_____
Use of drugs: Never:_____ Type / frequency: _____
Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne particles:_____ Noise:_____
Occupation/Work Environment: Please describe: _____
Do you have a living will or advanced directive? Yes No

- **Family medical history:**

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

- ***CONSTITUTIONAL SYMPTOMS***
  - Good general health lately..... Yes No
  - Recent weight change..... Yes No
  - Decreased appetite……. Yes No
  - Fever/nightsweats..... Yes No
  - Fatigue/weakness..... Yes No
  - Headaches..... Yes No
- ***EYES***
  - Eye disease or injury..... Yes No
  - Wear glasses/contact lenses..... Yes No
  - Blurred or double vision..... Yes No
  - Glaucoma/cataracts..... Yes No
- ***EARS/NOSE /THROAT***
  - Hearing loss or ringing..... Yes No
  - Earaches or drainage..... Yes No
  - Chronic sinus problems……..... Yes No
  - Nose bleeds..... Yes No
  - Mouth sores..... Yes No
  - Sore throat or voice change..... Yes No
  - Swollen glands in neck..... Yes No
- ***CARDIOVASCULAR***
  - Heart trouble..... Yes No
  - Chest pain or angina pectoris..... Yes No
  - Palpitation..... Yes No
  - Shortness of breath with walking or lying flat. Yes No
  - Swelling of feet, ankles or hands..... Yes No
- ***RESPIRATORY***
  - Chronic or frequent coughs..... Yes No
  - Spitting up blood..... Yes No
  - Shortness of breath..... Yes No
  - Asthma or wheezing..... Yes No
- ***GASTROINTESTINAL***
  - Loss of appetite..... Yes No
  - Change in bowel movements..... Yes No
  - Nausea or vomiting..... Yes No
  - Frequent diarrhea..... Yes No
  - Painful bowel movements or constipation..... Yes No
  - Rectal bleeding or blood in stool..... Yes No
  - Abdominal pain..... Yes No
  - Ulcer (stomach or duodenal)..... Yes No
- ***GENITOURINARY***
  - Frequent urination..... Yes No
  - Burning or painful urination..... Yes No
  - Awaken at night to urinate……. Yes No
  - Blood in urine..... Yes No
  - Change in force of stream when urinating..... Yes No
  - Incontinence or dribbling..... Yes No
  - Sores or discharge……. Yes No
  - Kidney stones..... Yes No
  - Sexual difficulty..... Yes No
  - Male - testicle pain/lumps..... Yes No
  - Female - pain with periods..... Yes No
  - Female - irregular periods..... Yes No
  - Female - vaginal discharge..... Yes No
  - Female - # of pregnancies..... _____
  - Female - # of miscarriages:..... _____
  - Female - date of last pap smear:..... _____
- ***MUSCULOSKELETAL***
  - Joint pain..... Yes No
  - Joint stiffness or swelling..... Yes No
  - Weakness of muscles or joints..... Yes No
  - Muscle pain or cramps..... Yes No
  - Back pain..... Yes No
  - Difficulty in walking..... Yes No
- ***INTEGUMENTARY (skin, breast)***
  - Rash or itching..... Yes No
  - Change in skin color..... Yes No
  - Change in hair or nails..... Yes No
  - Varicose veins..... Yes No
  - Breast pain..... Yes No
  - Breast lump..... Yes No
  - Breast discharge..... Yes No
- ***NEUROLOGICAL***
  - Frequent or recurring headaches..... Yes No
  - Light headed or dizzy..... Yes No
  - Convulsions or seizures..... Yes No
  - Numbness or tingling sensations..... Yes No
  - Shakes..... Yes No
  - Paralysis..... Yes No
  - Stroke..... Yes No
  - Head injury..... Yes No
- ***PSYCHIATRIC***
  - Memory loss or confusion..... Yes No
  - Nervousness..... Yes No
  - Depression..... Yes No
  - Difficulty sleeping..... Yes No
- ***ENDOCRINE***
  - Glandular or hormone problem..... Yes No
  - Thyroid disease..... Yes No
  - Diabetes *(insulin or non insulin -* ***circle one****)*..... Yes No
  - Excessive thirst or urination..... Yes No
  - Heat or cold intolerance..... Yes No
- ***HEMATOLOGIC/LYMPHATIC***
  - Slow to heal after cuts..... Yes No
  - Bleeding or bruising tendency..... Yes No
  - Anemia..... Yes No
  - Blood clots..... Yes No
  - Blood transfusion..... Yes No
  - Enlarged glands..... Yes No
- ***ALLERGIC/IMMUNOLOGIC***
  - History of skin reaction or other adverse reaction to: Yes No
    - Penicillin or other antibiotics..... Yes No
    - Morphine, Demerol, or other narcotics..... Yes No
    - Novocaine or other anesthetics..... Yes No
    - Aspirin or other pain remedies..... Yes No
    - Tetanus antitoxin or other serums..... Yes No
    - Iodine, merthiolate or other antiseptic..... Yes No
    - Other drugs/medications: _____
  - Known food allergies: _____
  - Environmental allergies: _____

Reviewed by:_____ Date:_____