GUTHRIE

Guthrie Weight Loss Center
Initial Appointment Questionnaire

Thank you for choosing Guthrie Weight Loss Center. If you wish to make an appointment with our office, this packet is to be filled out in its entirety. You may return the packet to the Guthrie Weight Loss Center by mail or in person; we will then contact you to schedule an appointment.

Program of Interest: ☐ **Medical Program** ☐ **Surgical** ☐ **Unsure**

Patient Information	**Name**	**Date of Birth**	**Gender** (circle one) **Male - Female**
Address / City / State / ZIP			
Home Phone	**Cell Phone**	**Work Phone**	
E-mail address	**Marital Status** Single - Married - Divorced - Widow - Other		
Employer	**Spouse's Employer (if applicable)**		
Emergency Contact (Name and relation)	**Emergency Contact Phone**		
Referral Source (circle one) Family/friend - Physician - Website - Web ad - Radio/TV ad - Print ad - Insurance company - Other:_____			

Physician Information	**Referring Physician / PCP (Name)**	
Location (city, state)	**Date of last visit**	**Date of next visit**
Preferred Pharmacy		**Phone**

Insurance Information	**Policyholder Name (if other than patient)**	
Primary Insurance (i.e. BC/BS, Aetna, etc.)		**Primary Insurance Phone #**
ID / Policy Number	**Group Number**	
Secondary Insurance Policyholder Name (if other than patient)		
Secondary Insurance (if applicable)		**Secondary Insurance Phone #**
ID / Policy Number	**Group Number**	

The information provided is correct to the best of my knowledge. My signature below authorizes Guthrie Weight Loss Center to communicate with me via email, phone, or other means indicated.

Signature: _____ **Date:** _____

Medical History	You may not be familiar with some terms, but mark all that apply.		
CONDITION	**MANAGEMENT** (Check all that apply)	**CONDITION**	**MANAGEMENT** (Check all that apply)
☐Type 2 Diabetes	□ Diet controlled □ Oral Medication □ Insulin	☐Congestive Heart Failure (CHF)	□ Medication □ Hospitalization
☐Hypertension (High Blood Pressure)	□ Diet controlled □ Medication Usual reading: _____ /	☐Coronary Disease (Heart Attack, Angina)	□ Medication □ Stents: _____ □ Bypass surgery
☐High cholesterol (Hyperlipidemia)	□ Diet controlled □ Medication	☐Liver Disease *(List type:_____)*	
☐Obstructive Sleep Apnea	□ Using CPAP □ CPAP prescribed, not used □ Using mouth spacer	☐Kidney Disease	□ Medication □ Dialysis Creatinine: _____
☐Gastroesophageal Reflux (GERD, heartburn)	□ Diet controlled □ Medication	☐Venous Insufficiency	□ Swelling □ Compression hose □ Ulcers
☐Arthritis / Joint Pain	□ Physical therapy □ Prior surgery	☐COPD (Emphysema or Chronic Bronchitis)	□ Medication □ Oxygen
☐Back Pain	□ Chiropractor / PT □ Medication □ Other:	☐Asthma	□ Medication □ Frequency of inhaler use: _____
☐Depression	□Therapy / counseling □ Medication	☐Gallstones	
☐Infertility / Polycystic Ovaries		☐Blood Clots in Leg / Lung (DVT/PE)	□ Blood thinner – current □ Blood thinner – past □ IVC filter
☐Irregular Menstrual Cycles		☐Cancer *(Type: _____)*	
☐Stress Urinary Incontinence (leakage)	□ Using pads □ Medication Leakage frequency: _____	☐Other:	
☐Thyroid disease	□ Medication □ Prior thyroid surgery	☐Other:	

Surgical History	You may not be familiar with some terms, but mark all that apply. Add anything not listed.	
SURGERY TYPE	**APPROACH**	**YEAR**
☐Appendix (appendectomy)	□ Laparoscopic □ Open □ I don't know	
☐Gallbladder (cholecystectomy)	□ Laparoscopic □ Open □ I don't know	
☐Hysterectomy	□ Laparoscopic □ I don't know □ Open □ Vaginal	
☐Previous bariatric surgery *List type:*	□ Laparoscopic □ Open	*Hospital:*

Family History	You may not be familiar with some terms, but mark all that apply.		
CONDITION	**FAMILY MEMBER**	**CONDITION**	**FAMILY MEMBER**
☐Type 2 Diabetes		☐Congestive Heart Failure (CHF)	
☐Hypertension (High Blood Pressure)		☐Coronary Disease (Heart Attack, Angina)	
☐High cholesterol (Hyperlipidemia)		☐Liver Disease *(List type:_____)*	
☐Obstructive Sleep Apnea		☐Kidney Disease	
☐Gastroesophageal Reflux (GERD, heartburn)		☐Venous Insufficiency	
☐Arthritis / Joint Pain		☐COPD (Emphysema or Chronic Bronchitis)	
☐Back Pain		☐Asthma	

Family History Cont.	You may not be familiar with some terms, but mark all that apply.		
CONDITION	**FAMILY MEMBER**	**CONDITION**	**FAMILY MEMBER**
☐Depression		☐Gallstones	
☐Infertility / Polycystic Ovaries		☐Blood Clots in Leg / Lung (DVT/PE)	
☐Irregular Menstrual Cycles		☐Cancer *(Type: _____)*	
☐Thyroid disease		☐ Sudden Death	
☐ Psychiatric Disease		☐Other:	
☐ Stroke		☐Other:	

Social History	Fill out everything to the best of your knowledge.			
TOBACCO USE	Do you smoke? YES - NO	Did you ever used to smoke? YES - NO I quit in _____ *(yr)*	Packs/day: _____ Years: _____	Willing to quit? YES - NO
ALCOHOL USE	Do you drink? YES - NO	_____ drinks per week of *(circle)* beer / wine / liquor		
SUBSTANCE USE	Do you use any of the following: □ Marijuana □ Ecstasy □ Heroin □ Meth(amphetamines) □ Cocaine □ Other:_____			
FITNESS HISTORY	Has a physician ever told you NOT to participate in a fitness or exercise program? YES - NO		REASON:	
	Is there anything that will prevent you from participating in a fitness program? YES - NO		REASON:	

Allergies	List all medication/food allergies, or indicate: ☐ *I have no known allergies.*

MEDICATION NAME	REACTION

Medications	List all current medications.		

MEDICATION	DOSE	SCHEDULE	PURPOSE
Example: *Metformin*	*500mg*	*1 pill twice a day*	*diabetes*

GUTHRIE

Guthrie Weight Loss Center
Initial Appointment Questionnaire

Review of Body Systems	You may not be familiar with some terms, but mark all symptoms that you are *currently* experiencing.		
GENERAL	□ Fevers or chills □ Loss of appetite □ Excessive sweating	**URINARY**	□Pain with urination □Kidney stones □Trouble starting/stopping stream □Leakage (incontinence)
EYES	□ Burning / irritation □ Change in vision □ Double vision	**SKIN / BREAST**	□ Skin lesion (new) □ Rash □ Changing mole □Breast lump (new)
EARS / NOSE / THROAT	□ Earaches □Nasal congestion □ Ringing in ears □Cough □ Nosebleeds □Sore throat	**HEMATOLOGIC**	□Easy bruising □Prolonged bleeding □Swollen glands
RESPIRATORY	□Wheezing □Pneumonia □Shortness of breath □ Asthma	**MUSCULOSKELETAL**	□Back or neck pain □Painful joints: _____ □Muscle aches □Muscle weakness
CARDIOVASCULAR	□Chest pain □Chest pressure □Palpitations / irregular heartbeats	**NEUROLOGICAL**	□Numbness or tingling □Seizures □Headaches □Dizziness / vertigo
GASTROINTESTINAL	□Nausea / vomiting □Constipation □Diarrhea □Abdominal pain	**SLEEP**	□Snoring loudly (according to partner) □Fatigue during daytime / nodding off

Mental Health History

1. Are you now or have you been in the past diagnosed with depression or bipolar disorder?
1. Are you now or have you been diagnosed in the past with anxiety?
2. Are you now or have you been in the past diagnosed with any other mental health issues?
3. Have you ever been diagnosed or treated for an eating disorder? If YES, what and how were you treated?
4. Were you ever the victim of sexual abuse?

Obesity History	1. How long have you been obese?	2. Highest adult weight (lbs.)?	3. Lowest adult weight (lbs.)?
4. What is your current weight?			
5. How does your weight limit you?			
6. What do you think is the reason for your weight gain?			
7. What do you see as your two biggest barriers to weight loss?			

GUTHRIE

Guthrie Weight Loss Center
Initial Appointment Questionnaire

Weight Management History	LENGTH OF TIME (MONTHS)	YEAR	WEIGHT LOST (lbs)	WEIGHT RE-GAINED (lbs)
Example: ***Low calorie diet***	*10 months*	*2002*	*30 lbs.*	*15 lbs.*
Low calorie diet				
Low fat diet				
Atkins diet				
Optifast® / Medifast®				
Phen-Fen				
Other prescription meds *(Name:_____)*				
Diet shots (B12, etc.) *(Name:_____)*				
Non-prescription diet pills *(Name:_____)*				
Doctor-supervised diet				
Registered Dietician (RD)				
Exercise program				
Nutrisystem®				
T.O.P.S.®				
Weight Watchers®				
Jenny Craig®				
LA Weight Loss:				
Other:				

The entire weight management history must be filled out, to the best of your knowledge. Do not write "All my life" or "Years" but be specific, as close as you can recall.

Sleep Assessment

1. How many hours of sleep do you get per night?
2. Do you feel rested when you wake up in the morning?
3. Has anyone ever told you that you stop breathing while you sleep?
4. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired. Use the scale below to choose the most appropriate number for each situation:

0= no chance of dozing
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

SITUATION	CHANCE OF DOZING	SITUATION	CHANCE OF DOZING
Sitting and reading		Lying down to rest in the afternoon when circumstances permit	
Watching TV		Sitting and talking to someone	
Sitting inactive in a public place (theater or meeting)		Sitting quietly after a lunch without alcohol	
As a passenger in a car for an hour without a break		In a car, while stopped for a few minutes in traffic	

Exercise History

1. Do you have any limitations or injuries that make exercise difficult? If YES, please describe.
2. Do you engage in any consistent exercise now? If YES, please describe. If NO, please tell us why.
3. Have you enjoyed exercise in the past? If YES, please describe. If NO, tell us what you did not like.
4. Have you ever stuck to a consistent exercise plan? If YES, for how long?
5. If you have never been able to stick to a consistent exercise plan, what has prevented you from doing so?

GUTHRIE

Guthrie Weight Loss Center
Initial Appointment Questionnaire

Demographics	Have you attended a Guthrie Weight Loss Center seminar? YES - NO Combined □ Medical □ Surgical □ Date: _____ Location: _____
RACE: □ Asian □ Black or African-American □ Caucasian or White □ Native American □ Hawaiian or Pacific Islander □ I choose not to identify	
ETHNICITY: □ Latino or Hispanic □ Not Latino or Hispanic	LANGUAGES SPOKEN: First: Other:

Upon completion, submit this information packet either *in person* or *by mail* to:

Guthrie Weight Loss Center
Guthrie Clinic
One Guthrie Square
Sayre, PA 18840

We want to safeguard your personal information as best we can. Please do not email or fax this packet.

Thank you, and best of luck as you begin this journey!

Would you be interested in receiving additional communication to the address(es) provided within this packet by Guthrie? YES NO

If YES, you are giving permission to Guthrie to send communication including, but not limited to e-newsletters, educational material, seminar and event invitations and program announcements, to me on a regular basis.

Guthrie will only send e-newsletters, educational material, seminar and event invitations, and announcements to the address(es) provided. □ EMAIL □ MAILING ADDRESS

Guthrie will provide an opt-out option on all emails to discontinue communication at any time.

Signature: _____ ***Date:*** _____

If you wish to no longer receive regular communication from Guthrie, please contact us at 570.887.4415.