INOVA™

2QUESTI

CONFIDENTIAL

Name (Last-First-Initial)

Address (Street-City-State-Zip)	Daytime Phone No.

Birth date (Month-Day-Year)	Email Address	Sex ☐ Male ☐ Female

Were you referred to Inova Medical Weight Loss? ☐ Yes ☐ No If yes, by whom? _____

Which physicians are currently treating you? Please give us their names and office numbers so we may collaborate for your safety.

☐

☐

☐

Weight History

What is your goal weight?	When did you last weigh this amount?

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (*e.g.* NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, *etc.*)

Weight Loss Method *(e.g. Stillman Diet)*	**How long was loss maintained?** *(e.g. 2 months)*	**Why did you stop treatment?** *(e.g. desired other foods)*	**Problems during treatment?** *(e.g. dizziness)*	**Which weight loss method do you consider your most successful? What accounted for that success?**

Medical History

Please list your medications – prescribed or over the counter

Medication Name	Dosage	Route	Frequency

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Weight Loss

History

CAT # 20348DT/R010315 • PKGS OF 100

INOVA™

2QUESTI

Please list any Allergies and your reaction:

Date of last Menstrual period: _____ Current method of contraception: _____
Plans for pregnancy within next 6 months?

Medical history: (e.g. diabetes, thyroid issues, cancer, cardiac history, etc)

Surgical history (give dates where possible):	Family history (mom, dad, grandparents and siblings):

Social Information

☐ Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? Cigarettes _____ Cigars _____
How many years? _____

☐ Any history of illicit drug use? ☐ Yes ☐ No If yes, what? _____ When? _____

☐ Do you have an Advance Directive? ☐ Yes ☐ No If yes, please provide a copy.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Medical Weight Loss

History

CAT # 20348DT/R010315 • PKGS OF 100

INOVA™

2QUESTI

A 24 Hour Dietary Recall (your typical day-to-day diet)

Action	Time	Meal Examples
Wake up		
Breakfast		
Mid-morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening snack		
Bedtime		
Other intake not specified above		

Indicate how many times per week you eat out (**including delivery/pickup**) and a general description of the types of food (*i.e.* fast food-burgers, fine dining, Thai, etc.). Are the majority of these meals with family or friends? ☐ Yes ☐ No

	Times per Week	Description
Breakfast		
Lunch		
Dinner		

What you drink throughout the day and quantity: _____

_____

What do you think in particular you struggle with when it comes to your diet (*i.e.* portion sizes, stress or emotional eating, etc.): _____

How do you feel that your weight has affected you (*i.e.* joint pains, depression, shortness of breath on minimal exertion, stress, etc.): _____

How many hours of sleep do you get each night? _____

How often do you exercise? ☐ Never ☐ Rarely ☐ Occasionally ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week

Has any doctor or other health care professional ever told you not to exercise? ☐ Yes ☐ No
Do you know of any reason why you should not exercise? ☐ Yes ☐ No
If you answered yes to either question, please explain: _____

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____ _____
Patient Signature Date Time

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Weight Loss

History

CAT # 20348DT/R010315 • PKGS OF 100