CYPRESS PHYSICIAN ASSOCIATION

It is with the greatest pleasure that we welcome you to the Cypress Physician Association. On behalf of our team of professionals, we thank you for choosing us and look forward to partnering with you on your weight loss journey. It is our mission to provide an evidence-based approach to weight loss and customize an individualized treatment plan for you.

To expedite your appointment, we have enclosed a health questionnaire that will provide us vital information and ask that you bring this completed to your first visit. We also ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if the below paperwork is not completed. The paper work should be filled out to the best of your knowledge due to a customized plan being made from information provided. Though follow up visits are around 15 minutes, please allow for one hour for your first visit to account for initial evaluation, EKG, and lab work.

If there are any questions prior to the first appointment please contact us at 281-537-0300.

Thank you and we look forward to working with you on this important decision you've made to live a healthier life.

Respectfully,

Elizabeth Couch FNP-C

Weight Loss- Medical History Form

Name: Age: Sex: Male

Family Physician: Phone:

May we contact this practitioner? Yes

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes
2. Are you under a doctor's care at the present time? Yes If yes, for what?
3. Are you taking any medications at the present time? Yes

   What: Dosages:
   What: Dosages:

4. Any allergies to any medications? Yes
5. History of High Blood Pressure? Yes
6. History of Diabetes? No At what age:
7. History of Heart Attack or Chest Pain? Yes
8. History of Swelling Feet Yes
9. History of Frequent Headaches? Yes

   Migraines? Yes
   Medications for Headaches:

10. History of Constipation (difficulty in bowel movements)? Yes
11. History of Glaucoma? Yes
12. **Gynecologic History**:

    Pregnancies: Yes Number: Dates:
    Natural Delivery or C-Section (specify): Natural
    Menstrual: Yes Onset:

Duration:
Are they regular: Yes
Pain associated: Yes
Last menstrual period:
Hormone Replacement Therapy: Yes
What:
Birth Control Pills: Yes Type:
Last Check Up:

13. **Serious Injuries**: Yes
Specify:
Date:

14. **Any Surgery**: Yes
Specify:
Date:

Specify:
Date:

15. **Family History**:

	Age	Health Disease	Cause of Death	Overweight?
Father:				Yes
Mother:				Yes
Brothers:				Yes
Sisters:				Yes

Has any blood relative ever had any of the following:

Glaucoma: Yes Who:
Asthma: Yes Who:
Epilepsy: Yes Who:
High Blood Pressure Yes Who:
Kidney Disease: Yes Who:
Diabetes: Yes Who:
Tuberculosis: Yes Who:
Psychiatric Disorder Yes Who:
Heart Disease/Stroke Yes Who:

Past Medical History: (check all that apply)

☐ Polio ☐ Measles ☐ Tonsillitis ☐ Jaundice ☐ Mumps ☐ Pleurisy ☐ Kidneys ☐ Scarlet Fever

☐ Liver Disease ☐ Lung Disease ☐ Whooping Cough ☐ Chicken Pox ☐ Rheumatic Fever

☐Bleeding Disorder ☐Nervous Breakdown ☐Ulcers ☐Gout ☐Thyroid Disease ☐Anemia
☐Heart Valve Disorder ☐Heart Disease ☐Tuberculosis ☐Gallbladder Disorder ☐ Psychiatric Illness
☐Drug Abuse ☐Eating Disorder ☐Alcohol Abuse ☐Pneumonia ☐Malaria ☐Typhoid Fever
☐Cholera ☐Cancer ☐Blood Transfusion ☐Arthritis ☐Osteoporosis

Other:

Nutrition Evaluation:

1. Present Weight: Height (no shoes): Desired Weight:
2. In what time frame would you like to be at your desired weight?
3. Birth Weight: Weight at 20 years of age: Weight one year ago:
4. What is the main reason for your decision to lose weight?
5. When did you begin gaining excess weight? (Give reasons, if known):
6. What has been your maximum lifetime weight (non-pregnant) and when?
7. Previous diets you have followed: Give dates and results of your weight loss:
8. Is your spouse, fiancée or partner overweight? Yes
9. By how much is he or she overweight?
10. How often do you eat out?
11. What restaurants do you frequent?
12. How often do you eat "fast foods?"
13. Who plans meals? Cooks? Shops?
14. Do you use a shopping list? Yes

15. What time of day and on what day do you shop for groceries?

16. Food allergies:

17. Food dislikes:

18. Food you crave:

19. Any specific time of the day or month do you crave food?

20. Do you drink coffee or tea? Yes How much daily?

21. Do you drink cola drinks? Yes How much daily?

22. Do you drink alcohol? Yes

What?
How much?
Weekly?

23. Do you use a sugar substitute? Butter? Yes Margarine? Yes

24. Do you awaken hungry during the night? Yes

What do you do?

25. What are your worst food habits?

26. Snack Habits:

What?
How much?
When?

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

29. Smoking Habits: (select only one)

- ○ You have never smoked cigarettes, cigars or a pipe.
- ○ You quit smoking years ago and have not smoked since.
- ○ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
- ○ You smoke 20 cigarettes per day (1 pack).
- ○ You smoke 30 cigarettes per day (1-1/2 packs).
- ○ You smoke 40 cigarettes per day (2 packs).

30. Describe your usual energy level:

31. Activity Level: (select only one)

- ○ Inactive- no regular physical activity with a sit-down job
- ○ Light activity- no organized physical activity during leisure time
- ○ Moderate activity- occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling
- ○ Heavy activity- consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
- ○ Vigorous activity- participation in extensive physical exercise for at least 60 minutes per session 4 times per week

32. Behavior style: (select only one)

- ○ You are always calm and easygoing.
- ○ You are usually calm and easygoing.
- ○ You are sometimes calm with frequent impatience.
- ○ You are seldom calm and persistently driving for advancement.

- ○ You are never calm and have overwhelming ambition.
- ○ You are hard-driving and can never relax.

33. Please describe your general health goals and improvements you wish to make:

Please complete the following log with your current food choices. This will help us guide you to make healthier choices that fit your lifestyle. The more detailed you can be, the more information we will have to customize your plan.
This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Typical Daily Food Log (1 day – minimum). Please include Meals, Snacks, Beverages and Estimate Portion Sizes

	Time	What was consumed	Portion Size	Home/Restaurant	With who
Breakfast:					
Lunch:					
Dinner:					
Snack					
Drinks					

Screening for Sleep Apnea

This short quiz is designed to help you to recognize possible sleep apnea so that you can realize that there can be relief for your symptoms. Please select yes or no next to any that apply to you.

- [ ] Yes Do you wake up in the morning tired and foggy, not ready to face the day?
- [ ] Yes Do you have headaches in the morning?
- [ ] Yes Are you very sleepy during the day?
- [ ] Yes Do you fall asleep easily during the day?
- [ ] Yes Do you have difficulty concentrating, being productive and completing tasks at work?
- [ ] Yes Do you carry out routine tasks in a daze?
- [ ] Yes Have you ever arrived home in your car but couldn't remember the trip from work?
- [ ] Yes Have you ever fallen asleep at a stop light or stop sign?
- [ ] Yes If you doze off, do you sometimes wake up with a snort?
- [ ] Yes Are you having serious relationship problems at home, with friends and relatives or at work?
- [ ] Yes Are you afraid that you may be out of touch with the real world, enable to think clearly, losing your memory or emotionally ill?
- [ ] Yes Do your friends tell you that you are not like yourself?
- [ ] Yes Are you depressed?
- [ ] Yes Are you irritable and angry, especially first thing in the morning?
- [ ] Yes Are you overweight?
- [ ] Yes Do you have high blood pressure?
- [ ] Yes Do you have pains in your bones and joints?
- [ ] Yes Do you have trouble breathing through your nose?
- [ ] Yes Do you often have a drink of alcohol before going to bed?
- [ ] Yes If you are a man, is your collar size 17 inches (42 centimeters) or larger? 16 inches for a female?
- [ ] Yes Do you snore loudly at night?
- [ ] Yes Do you have frequent pauses in breathing while you sleep (you stop breathing for ten seconds or longer)?
- [ ] Yes Are you restless during sleep, tossing and turning from one side to another?
- [ ] Yes Does your posture during sleep seem unusual (do you sleep sitting up or propped up by pillows)?
- [ ] Yes Do you have insomnia (waking up frequently and without a reason)?
- [ ] Yes Do you have to get up to urinate several times during the night?
- [ ] Yes Have you wet your bed?
- [ ] Yes Have you fallen from bed?

How many "Yes" answers do you have? ☐

If you answered "yes" to *any* of these questions, you *may* have sleep apnea. However, if you answered "yes" to any of the following especially important four questions, this *strongly suggests* that sleep apnea is the problem.

1 – are you sleepy during the day
2 – do you fall asleep easily during the day
3 – do you snore loudly each night while you sleep
4 – do you have frequent pauses in breathing