Patient Questionnaire:

First Name: ____________________

Last Name: ____________________

Date of Birth: ____________________

Medication Allergies: ____________________

Medical History:

Do you currently have or have you ever had any of these conditions?:

Yes	No	Condition
		Eating disorder (ex. anorexia, bulimia, binge eating disorder)
		Mental health disorder (ex. Bipolar, schizophrenia, body dysmorphia, suicidal behavior)
		Pancreatic disorder or cancer (acute or chronic pancreatitis)
		Thyroid disorder (MEN 2A/2B) or cancer (medullary thyroid cancer)
		Renal disorder or cancer
		Reflux
		Type 1 or Type 2 Diabetes Mellitus
		Cardiac disorder (heart attack, heart failure, angina)
		Stroke
		Delayed Gastric Emptying
		Inflammatory Bowel Disease (Ulcerative Colitis, Crohn's Disease)

If yes, please explain:

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Please list any other medical conditions not listed above:

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Please list all medications / vitamins / supplements you are taking, including B12 injections:

Have you ever taken any medications for weight loss OR diabetes before? If yes, list below:

Are you currently pregnant, breast feeding, or actively trying to get pregnant? **YES** **NO**

Are you currently or have you ever been treated for drug/alcohol abuse? **YES** **NO**

Have you had any bariatric or weight loss surgery in the last year? **YES** **NO**

Do you practice intermittent fasting or cultural fasting? **YES** **NO**

Lifestyle:

Do you currently exercise? If yes, what kind of exercise and how many times per week?

Do you follow a specific diet or calorie restriction?

Do you have any dietary restrictions or food allergies?

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What is your goal weight?

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