Copper Valley Medical
Caring, Compassionate Healing

Weight Loss Management

Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

Weight: _____ Height: _____ BMI: _____ Goal Weight: _____ lbs.

- At what age did you first become overweight? (age)_____ (year) _____
- How or why did your weight gain start? _____
- What do you think is the reason for your weight problem? _____
- What has been your highest weight (excluding pregnancy)? _____ lbs. Age at that time: _____
- What was your lowest, normal adult weight? ___ lbs. Age at that time: _____
- Have you previously attempted to lose weight? **Y N**
  - If yes, how much did you lose? __ lbs How long did this take? _____
- What method(s) of weight loss have you tried? Please circle all that apply None

Adkins	Mediterranean	South Beach	Weight Watchers	Semaglutide
Jenny Craig	Keto	Nutrisystem	MIC/B_{12}	Tirzepatide
Phentermine	Contrave	Qsymia	HCG	Intermittent Fasting

Which method(s) worked best for you? _____
How much did you lose? _____ lbs How long did you keep it off? ____ weeks/months/years

Do you think you overeat or eat poor quality foods? __**Y** __**N**

Are you able/willing to make a lifestyle change to lose weight and keep it off? __**Y** __**N**

Are you able to modify your diet to lose weight? __**Y** __**N**

Are you able to self-inject with a small, painless needle? __**Y** __**N**

Do you have drug or food allergies? __**Y** __**N** __ Sulfa Drugs __ Latex Powder __ Penicillin __ Other

Have you ever been told to avoid certain foods or drugs? __**Y** __**N** _____

Have you been told to avoid grapefruit juice because of interaction with medication? __**Y** __**N**
Are you now, or do you intend to become pregnant in the next 12 months? __**Y** __**N**

Do you exercise on a regular basis? Y N If yes, please describe the type and frequency of your exercise:

_____
_____
_____

Diet:

Typical Breakfast: _____ Time: _____

Typical Lunch: _____ Time: _____

Typical Dinner: _____ Time: _____

Snacks: _____

Water Intake: _____ oz/day Coffee intake _____ Soda intake: _____

Current Medications:

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Current Supplements:

Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____

Have you been diagnosed with any of the following chronic diseases?

Asthma __ Hypertension __ Diabetes Type I __
Heart Disease__ Seizure Disorder __ Diabetes Type II __
Migraine HA __ Kidney Disease __
Depression __ High Cholesterol __

Do you have, or have you had any of the following cancers or tumors:

Hypothalamus __ Pituitary Gland __ Prostate Gland __ Thyroid __
Breast __ Uterus __ Ovary __ MEN II __

Smoking History:

Do you currently smoke? N __ Yes: Cigarettes __ (Packs per day) Cigars __ (Cigars/day) Pipe __ (Times/day) Other: _____

__Past or current smoker Date last smoked: _____ Packs/Day Smoked: _____

Bowel Movements:

How many bowel movements do you typically have each day: 0—1—2—more
How would you describe your recent stools? __Solid; no strain to pass __Hard; difficult to pass __Loose
__Foul-smelling __Floating __Greenish __White/Clay-colored

Do you use laxatives? **Y N** How frequently? __Daily 3+/Week 3+/Month __ Rarely or Never
Have you recently noticed blood on the tissue or in the water after your stool: **Y N**
Have you noticed or suspected hemorrhoids: **Y N**
If yes, what level of pain: 1--------5--------10 (10 is worst)

Energy Level:

What has your energy level been for the past several days? 1--------5--------10 (10 is best)
How much sleep is normal for you? 4—6—8 –10 hours per night

Stress:

How would you rate your current stress level: 1-------5--------10 (10 is worst)
What is the primary cause of your stress? _____
Would you like us to make some supplement recommendations to help your body deal with stress? **Y N**

Hospitalizations: Age/Reason _____
Age/Reason _____
Age/Reason _____

Surgeries: Age/Reason _____
Age/Reason _____
Age/Reason _____
Age/Reason _____

Have you recently had any laboratory studies (blood, urine) or imaging (x-rays, CT, MRI, Ultrasound) Y N

Recent Labs: CMP CBC/Diff TSH Other: _____

Colonoscopy: _____ Last PSA: _____

Patients Considering Semaglutide or Tirzepatide

Some clinical research studies have suggested a link between use of semaglutide or tirzepatide and cancers of the thyroid gland call Multiple Endocrine Neoplasia Type II (MEN II), and acute pancreatitis, and/or gallbladder disease. If you or a close family member have a medical history of these conditions, please tell us.

Patients Considering Contrave

Do you have now or in the recent past, thoughts of suicide, dying, committing suicide? __Y __N
Do you have feelings of anxiety, restlessness, panic, irritability, aggression, anger or other changes in behavior? __Y __N
Are you dependent on opioid medications, or are you taking medication to help stop taking opioids? __Y __N

Patients Considering Phentermine

Do you have now or in the recent past any of the following?
__Cardiovascular diseases __Uncontrolled hypertension __ Stroke __ Arrhythmia __ Coronary Artery Disease
__Congestive Heart Failure __ Heart Attack (MI) __Glaucoma __Hyperthyroidism __ History of addiction to drugs

_____ _____
Signature of Patient Date