MEN'S MEDICAL
WEIGHT LOSS CENTER
SPECIALISTS IN WEIGHT LOSS FOR MEN

BASIC INFORMATION

First Name/Last Name:

Date of Birth:

Address:

Mobile Number:

Email address:

Primary Care Physician:

HEALTH INFORMATION

Health Problems: check all that apply

- ☐ Diabetes
- ☐ Prediabetes
- ☐ Hypertension
- ☐ Coronary Artery Disease/Heart Attack/Stent Placement
- ☐ Atrial Fibrillation
- ☐ Palpiations
- ☐ GERD (Reflux)
- ☐ Sleep Apnea
- ☐ Migraine Headaches
- ☐ Irritable Bowel Syndrome
- ☐ Glaucoma
- ☐ Seizures
- ☐ Gout
- ☐ Gallstones
- ☐ Kidney Stones

List all medications and dosages below:

Medication Name	Tablet Strength	Times per day taken	Approximate date started

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Family History: do you have family members with weight problems? *check all that apply.*

- ☐ No, no other members in my family have weight problems.
- ☐ Yes, the following family members have weight problems:

- ☐ Father
- ☐ Mother
- ☐ sibling(s)
- ☐ son/daughter(s)

Family Medical History: do any family members have any of the following conditions?

- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Alcohol Overuse
- ☐ Depression
- ☐ No family members with any of the above conditions

When did your weight problems start? *Check one.*

- ☐ In childhood
- ☐ At puberty
- ☐ As an adult
- ☐ Middle age
- ☐ After retirement

When did you gain your most weight? *Check one.*

- ☐ At the end of high school.
- ☐ One year ago.
- ☐ Five years ago.
- ☐ Ten years ago.
- ☐ 20 years ago.

What was your highest weight?_____ pounds

What was your lowest weight in your adult life? _____ pounds

Diets Tried in the Past: *complete all relevant boxes.* Use empty boxes to include diets not mentioned.

Diet Tried	Effective Yes/No	For How Long?	Reason for Stopping
South Beach Diet			
Ketogenic Diet			
Weight Watchers			
Intermittent Fasting			
Meal Replacement			
Plant Based Diet			
Mediterranean Diet			
High Protein Diet			

Weight Loss Medications: complete areas if associated weight loss medications have been tried. Enter in others not listed. Leave all blank if no medications ever used.

Medication Name	Effective Yes/No	For How Long?	Reason for Stopping
Phentermine			
Qsymia			
Contrave			
Metformin			
Ozempic			
Saxenda/Liraglutide			
Ally			
Topamax			
Wellbutrin/Bupropion			

Have you ever undergone weight loss surgeries or procedures? Check any that apply.

- [ ] Adjustable gastric band.
- [ ] Sleeve Gastrectomy
- [ ] Gastric bypass
- [ ] Balloon insertion

What would you like your weight to be? _____ pounds

How would you rate the support that your family and people around you provide for you on a scale of 1 to 10 (1 is low support, 10 is very high support)?

- [ ] 1 - 2
- [ ] 3 - 5
- [ ] 6 - 8
- [ ] 9 - 10
- [ ] Not applicable to me

Which barriers are keeping you from reaching your weight loss goals? Check all that apply.

- [ ] Not enough information
- [ ] Physical limitations that limit exercise
- [ ] Hunger that is hard to control
- [ ] Social events that prevent adherence
- [ ] Frequent travel that forces poor eating habits and limits exercise.
- [ ] Cravings for sweets
- [ ] Eating habits of others around you
- [ ] Family genetics
- [ ] Current medications
- [ ] Other: _____

On a scale of 1 to 10, how willing are you to make lifestyle changes?

- [ ] 1 - 3
- [ ] 4 - 6
- [ ] 7 - 9
- [ ] 10

Do you experience any eating triggers that compel you to eat when you are not necessarily hungry? Check all that apply.

- [ ] Boredom
- [ ] Stress
- [ ] Emotions
- [ ] Family Issues
- [ ] Other: _____
- [ ] Not applicable.

Which foods do you eat when triggered? Check all that apply.
Ice cream

- [ ] Chips
- [ ] Cake/pie
- [ ] Candy
- [ ] SandwichCereal
- [ ] Cookies
- [ ] Chocolate
- [ ] Meat
- [ ] Other: _____
- [ ] Not applicable.

If you have been diagnosed with low Testosterone which treatments have you used? Check all that apply.

- [ ] Injections
- [ ] Topicals
- [ ] Pellets
- [ ] Other: _____
- [ ] Not applicable

Do you experience any of the following? Check all that apply.

- [ ] Lack of energy
- [ ] Reduced libido
- [ ] Erectile dysfunction
- [ ] How many hours per night do you sleep? Check one.
- [ ] Less than 4 hours
- [ ] 4 to 5 hours
- [ ] 6 hours
- [ ] 7 - 8 hours
- [ ] More than 8

How do you rate your sleep quality on a scale of 1 to 10, ten being excellent sleep? Check one.

- [ ] 1 to 2
- [ ] 3 to 5
- [ ] 6 to 8
- [ ] 9 to 10

Do you wake up in the middle of the night to eat?

- [ ] Yes, often.
- [ ] Yes, sometimes.
- [ ] No, never.

Do you have problems falling or staying asleep? Check one.

- [ ] No, I fall asleep easily and sleep through the night.
- [ ] Yes, I have trouble falling asleep.
- [ ] Yes, I have trouble staying asleep, waking up in the middle of the night.
- [ ] Yes, I have trouble falling and staying asleep.

If you use sleep aids, which ones? Check all that apply.

- [ ] No sleep aids used.
- [ ] CBD oil.
- [ ] Melatonin.
- [ ] Benadryl.
- [ ] CBC
- [ ] Ambien/Zolpidem
- [ ] Other: _____

Do you ever eat during the hours between dinner and bedtime? Check one.

- [ ] No
- [ ] Yes, sometimes.
- [ ] Yes, frequently.

How would you rate your stress on a scale of 1 to 10? Check one.

- [ ] 1
- [ ] 2 to 5
- [ ] 6 to 9
- [ ] 10
- [ ] Not applicable, no stress at all.

Which situations have occurred to you in the last month? Check all that apply.

- [ ] Periods of time when you felt down or depressed
- [ ] Felt less interesting in doing things that you normally like to do
- [ ] Irritable.
- [ ] Inability to concentrate
- [ ] Nervous or anxious
- [ ] Felt compelled to complete certain behaviors repeatedly
- [ ] Found yourself preoccupied with food
- [ ] Been concerned about your use of alcohol

Have you ever been in therapy for emotional or psychological issues?

- [ ] Yes
- [ ] No

Which meals do you eat routinely? Check all that apply.

Breakfast
Lunch
Dinner
None, eat when hungry at any time of the day.

How many times per day do you snack? Check one.

- [ ] None.
- [ ] 1 - 2
- [ ] 3 - 4
- [ ] Greater than 5

Which snacking pattern best describes you? Check one.

- [ ] Do not snack.
- [ ] Late night snackingBetween meals
- [ ] No pattern to your snacking
- [ ] Grazing

Who does the grocery shopping? Check all that apply.

- [ ] I do the grocery shopping.
- [ ] Spouse/Partner
- [ ] Son/daughter
- [ ] Other

Who prepares the meals in your household? Check all that apply.

- [ ] I do the grocery shopping.
- [ ] Spouse/Partner
- [ ] Son/daughter
- [ ] Other

How many days per week do you eat out at a restaurant? Check one.

- [ ] Zero times per week.
- [ ] Once per week
- [ ] Two to five times per week
- [ ] Daily

How often do you eat fast food? Check one.

- [ ] Zero times per week.
- [ ] Once per week
- [ ] Two to five times per week
- [ ] Daily

Which of the following drinks do you consume at least once per week? Check all that apply.

- [ ] Black coffee
- [ ] Coffee with sugar
- [ ] Coffee with cream
- [ ] Tea
- [ ] Juice
- [ ] Energy drinks
- [ ] Soda
- [ ] Diet soda

- [ ] Milk
- [ ] Alcohol
- [ ] Water
- [ ] Other: _____

Do you smoke? Check one.

- [ ] No
- [ ] Yes, less than 1 pack per day
- [ ] Yes, about 1 pack per day
- [ ] Yes, more than 1 pack per day

How much alcohol do you drink? Check one.

- [ ] I do not drink any alcohol
- [ ] 1 per day
- [ ] 2 per day
- [ ] more than 3 per day

If you consume alcohol, what type of drinks? Check all that apply.

- [ ] Not applicable
- [ ] Wine
- [ ] Beer
- [ ] Vodka
- [ ] Whisky/bourbon/scotch
- [ ] Other: _____

What type of physical activity do you engage in? Check all that apply.

- [ ] No exercise
- [ ] Walking
- [ ] Running
- [ ] Resistance exercises (weight training)
- [ ] Pool exercises
- [ ] Yoga
- [ ] Golf
- [ ] Tennis
- [ ] Pickleball
- [ ] Other: _____

If you count your steps with your phone or Fitbit, how many do you average per day? Check one.

- [ ] Do not count or use these devices
- [ ] Less than 5,000 steps per day
- [ ] 5,000 to 8,000 steps per day
- [ ] greater than 8,000 steps per day