VIP WeightLoss *MD*.

PATIENT DEMOGRAPHICS

DATE _____

FIRST NAME/ MI_____ BIRTH DATE_____ AGE _____

LAST NAME_____ SEX/GENDER_____

ADDRESS 1_____ HOME PHONE_____

ADDRESS 2_____ CELL PHONE_____

CITY_____ WORK PHONE _____

STATE _____ ZIP CODE_____ EXTENSION_____

COUNTRY _____ OCCUPATION_____

HOW DID YOU FIND OUT ABOUT THE PROGRAM?

1. IF BY A CURRENT PATIENT, NAME: _____

2. IF BY ADVERTISEMENT: RADIO ( ) MAGAZINE ( ) TV ( ) NEWSPAPER ( )
INTERNET ( )

3. OTHER (please describe) _____

PATIENT EMAIL ADDRESS_____

PCP OR OBGYN NAME_____ PCP/OBGYN PHONE_____

BEHAVIORAL DATA

DO YOU THINK YOUR BIGGEST PROBLEM IS:

( ) OVER EAT AT MEALS ( ) SNACKS BEFORE MEALS ( ) SLOW METABOLISM

I AM MOST HUNGRY AT:

( ) NO DIFFERENCE ( ) LUNCH TIME ( ) DINNER TIME ( ) AFTER DINNER

I OVER EAT AT:

( ) BOTH MEALS AND SNACKS ( ) MEAL TIME ONLY ( ) SNACKS ONLY

COFFEE OR OTHER CAFFEINATED DRINKS MAKE ME FEEL:

( ) NO DIFFERENT ( ) SLIGHTLY HYPER ( ) VERY HYPER ( ) SO BAD, I AVOID THEM

CRAVE CARBOHYDRATES: ( ) NO ( ) ALL MONTH ( ) PRE-MENSTRUAL

OVER EAT FATTY FOODS: ( ) NO ( ) YES

CHRONIC CONSTIPATION: ( ) NO ( ) YES

I HAVE WATER RETENTION: ( ) NO ( ) YES

I FEEL LETHARGIC: ( ) NOT AT ALL ( ) MILDLY ( ) VERY

MY FAVORITE AEROBIC ACTIVITIES ARE:

( ) WALKING ( ) JOGGING ( ) CYCLING ( ) STEP AEROBICS

( ) SWIMMING ( ) STAIR MASTER ( ) STATIONARY BIKE

QUESTIONNAIRE PAGE 1

ARE YOU ALLERGIC TO ANY MEDICATIONS? ( ) YES ( ) NO

PLEASE INDICATE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS:

( ) SYNTHROID ( ) THYROID EXTRACT ( ) HERBAL MEDS ( ) CYTOMEL
( ) TENUATE ( ) DIETHYLPROPION ( ) LIBRAX ( ) PHENTERMINE
( ) FASTIN ( ) ADIPEX-P ( ) PHENDIMETRAZINE

ARE YOU CURRENTLY TAKING AN MAO INHIBITOR? (AN MAO INHIBITOR IS AND OLDER MEDICATION SELDOM USED ANYMORE FOR PSYCOSIS)?
( ) YES ( ) NO

ARE YOU TAKING ANY MEDICATION FOR HYPER ACTIVE DISORDER?
( )YES ( ) NO

ARE YOU CURRENTLY TAKING ANY ANTIDEPRESSANTS?
( ) YES ( ) NO

ARE YOU CURRENTLY TAKING ANY HIGH BLOOD PRESSURE MEDICATION?
( ) YES ( ) NO

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME:	**DOSAGE**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

QUESTIONNAIRE PAGE 2

DO YOU HAVE ANY SERIOUS MEDICAL PROBLEMS? ( ) YES ( ) NO

IF YES, PLEASE EXPLAIN: _____

_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

If yes, please explain:

1. HEART ATTACK: ( ) YES ( ) NO _____

2. A.D.D / A. D. H. D. ( ) YES ( ) NO _____

3. ARRYTHMIA: ( ) YES ( ) NO _____

4. UNCONTROLLED HYPERTENSION:
( ) YES ( ) NO _____

5. DIABETES: ( ) YES ( ) NO _____

6. STROKE: ( ) YES ( ) NO _____

7. CARDIAC SURGERY: ( ) YES ( ) NO _____

8. GASTRIC SURGERY FOR WEIGHT LOSS
( ) YES ( ) NO _____

QUESTIONNAIRE PAGE 3

ANY HISTORY OF THE FOLLOWING: **IF YES, EXPLAIN (add'l. space below):**

1. DRUG ABUSE: ( ) YES ( ) NO _____

2. KIDNEY DISORDER: ( ) YES ( ) NO _____

3. SEIZURE DISORDER: ( ) YES ( ) NO _____

4. GLAUCOMA: ( ) YES ( ) NO _____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN FULLY:

Item # _____ Explain: _____

_____

Item # _____ Explain: _____

_____

Item # _____ Explain: _____

_____

Item # _____ Explain: _____

_____

QUESTIONNAIRE PAGE 4

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

LOSS OR THINNING OF EYEBROWS:	( ) YES	( ) NO
LOW SEX DRIVE:	( ) YES	( ) NO
ABDOMINAL BLOATING:	( ) YES	( ) NO
DRY OR THINNING OF HAIR:	( ) YES	( ) NO
THICKENING OF THE SKIN:	( ) YES	( ) NO
PUFFY FACE:	( ) YES	( ) NO
COLD INTOLERANCE:	( ) YES	( ) NO
DEPRESSION:	( ) YES	( ) NO
COLD HANDS OR FEET:	( ) YES	( ) NO
JOINT OR MUSCLE PAIN:	( ) YES	( ) NO
THIN, BRITTLE FINGER NAILS:	( ) YES	( ) NO

QUESTIONNAIRE PAGE 5

BERLIN QUESTIONNAIRE

1. DO YOU SNORE?

( )YES ( )NO ( ) DON'T KNOW

IF YOU ANSWERED YES, PLEASE ANSWER QUESTIONS #2-9. IF YOU ANSWERED NO OR DON'T KNOW, PLEASE SKIP TO QUESTION #10:

2. YOUR SNORING IS:

( )SLIGHTLY LOUDER THAN BREATHING ( )AS LOUD AS TALKING
( )LOUDER THAN TALKING ( )VERY LOUD, CAN BE HEARD IN NEXT ROOM

3. HOW OFTEN DO SNORE?

( )NEARLY EVERY DAY ( )3-4 WEEK ( )1-2 WEEK ( )1-2 MONTH
( ) NEARLY NEVER

4. HAS YOUR SNORING EVER BOTHERED OTHER PEOPLE?

( )YES ( )NO ( ) DON'T KNOW

5. HAS ANYONE NOTICED THAT YOU QUIT BREATHING DURING YOUR SLEEP?

( )NEARLY EVERY DAY ( )3-4 WEEK ( )1-2 WEEK ( )1-2 MONTH ( ) NEVER

6. HOW OFTEN DO YOU FEEL TIRED OR FATIGUED AFTER YOUR SLEEP?

( )NEARLY EVERY DAY ( )3-4 WEEK ( )1-2 WEEK ( )1-2 MONTH ( ) NEVER

7. DURING YOUR WAKING TIME, DO YOU FEEL TIRED OR FATIGUED AFTER YOU SLEEP?

( )NEARLY EVERY DAY ( )3-4 WEEK ( )1-2 WEEK ( )1-2 MONTH ( ) NEVER

8. HAVE YOU EVER NODDED OFF OR FALLEN ASLEEP WHILE DRIVING A VEHICLE?

( )YES ( )NO

9. HOW OFTEN DOES THIS OCCUR?

( )NEARLY EVERY DAY ( )3-4 WEEK ( )1-2 WEEK ( )1-2 MONTH ( ) NEVER

10. DO YOU HAVE HIGH BLOOD PRESSURE?

( )YES ( )NO ( )DON'T KNOW