Main Line Health Comprehensive Weight and Wellness Program

HEALTH INFORMATION PACKET

Thank you for choosing the Main Line Health Comprehensive Weight and Wellness Program.

In order to maximize your first visit to our office, it would be helpful if you could complete this health information packet ahead of time. You may bring your completed form with you to the appointment; however, our providers appreciate and prefer the chance to review your answers ahead of time to best meet your individual needs. For your convenience, this form can be found in the patient forms section at **mainlinehealth.org/weight** and is available to print or complete and submit online. If you require assistance in completing the health packet or have questions, please call **484.476.6230** for assistance. Our team will be happy to help you.

Thank you!

Main Line Health®

Comprehensive Patient Health Data

DEMOGRAPHICS:

PATIENT NAME: ___________________________________ DATE OF BIRTH: _________________ AGE: __________ GENDER: □ MALE □ FEMALE

ADDRESS: ____

CITY: ____ STATE: __________ ZIP: ____________

EMAIL: ____

PRIMARY PHONE: __________________________ CELL PHONE: ______________________________ WORK PHONE: __________________________

May we leave a message at either of these phone numbers? □ Yes □ No

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ PARTNERED

EMPLOYED: ☐ YES ☐ NO, IF SO, OCCUPATION: ____________________________________ EMPLOYER: _______________________________

How did you hear about us?

□ Billboard □ Brochure □ Health Fair □ Health Plan □ Internet □ Jeff Now □ Mass Mailing □ Newspaper □ Ongoing Care □ Other

□ Patient □ Phys Offer/ER □ Relative □ Radio □ TV □ Word of Mouth

PHARMACY NAME ______________________________ **PHONE #:** _____________________ **PREFERRED LAB:** ______________________________

PHYSICIAN INFORMATION:

REFERRING PHYSICIAN NAME: ______________________________________ PHONE: _______________________ FAX: ________________________

PRIMARY PHYSICIAN NAME: ____ PHONE: _______________________ FAX: ________________________

PHYSICIAN NAME: ______________________________________ PHONE: _______________________ FAX: ________________________

SPECIALTY: ____

PHYSICIAN NAME: ______________________________________ PHONE: _______________________ FAX: ________________________

SPECIALTY: ____

PHYSICIAN NAME: ______________________________________ PHONE: _______________________ FAX: ________________________

SPECIALTY: ____

MEDICATIONS & SUPPLEMENTS:

ALL PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS/MINERALS (E.G., CALCIUM, ONE-A-DAY), HERBALS (E.G., ST. JOHN'S WORT), TYLENOL, ADVIL, EX-LAX.

PRESCRIPTION NAME	DOSE (E.G., "MG") & FREQUENCY	PRESCRIPTION NAME	DOSE (E.G., "MG") & FREQUENCY

ALLERGIES:

PLEASE LIST ALL MEDICATIONS, FOODS, SUBSTANCES YOU ARE ALLERGIC TO AND INDICATE WHAT HAPPENS WHEN YOU ARE EXPOSED TO IT (EXAMPLE: PENICILLIN > RASH)

PAST MEDICAL HISTORY:

PLEASE CHECK ANY OF YOUR CURRENT OR PAST MEDICAL CONDITIONS

GENETIC CONDITIONS
CANCER
TYPE____________
CORONARY ARTERY DISEASE
BLEEDING PROBLEM
BLOOD CLOT
HEART ATTACK
ATRIAL FIBRILLATION
PALPITATIONS/PVCs
HEART VALVE DISORDER
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HIGH TRIGLICERIDES
LEG SWELLING
STROKE
ARTHRITIS
BACK PAIN
JOINT PAIN
FIBROMYALGIA
PLANTAR FASCIITIS
MAJOR INJURY
TYPE______________
SCIATICA

DIABETES
GESTATIONAL DIABETES LOW
TESTOSTERONE
MALE PATTERN HAIR GROWTH
(WOMAN) METABOLIC
SYNDROME PREDIABETES
THYROID DISEASE
CELIAC DISEASE
CROHN'S/UC
DIVERTICULOSIS
FATTY LIVER DISEASE
GALLSTONES
STOMACH ULCERS
HEARTBURN/GERD
HEPATITIS
IRRITABLE BOWEL SYNDROME
PANCREATITIS
SLEEP APNEA
SNORING
LUNG DISEASE
PICKWICKIAN SYNDROME
COPD
ASTHMA

DECREASED LIBIDO
ENDOMETRIOSIS
INFERTILITY
IRREGULAR MENSUS
MENOPAUSE
POLYCYSTIC OVARIAN SYNDROME
URINARY INCONTINENCE
OVERACTIVE BLADDER
INSOMNIA
ANXIETY
ADHD
DEPRESSION
BIPOLAR
PTSD
AUTISM SPECTRUM DISORDER
ANOREXIA
BULIMIA
SUBSTANCE ABUSE
GLAUCOMA
HEADACHE/MIGRAINE
SEIZURES
CONCUSSION
PSEUDOTUMOR CEREBI

DISCOLORED SKIN
SKIN RASHES
SKIN TAGS
LEG/FOOT ULCERS
VARICOSE VEINS
VENOUS INSUFFICIENCY
IMMUNOSUPREESSED
CHRONIC INFECTIOUS DISEASE
RECURRENT INFECTIONS:
YEAST
UTI
SKIN/CELLULITIS
SINUSITIS
EAR/THROAT
BRONCHITIS
MAJOR INFECTION
TYPE__________
GOUT
KIDNEY DISEASE
KIDNEY STONES
LOW SODIUM OR POTASSIUM
LOW IRON
LOW VITAMIN D
LOW B12

OTHER:______________

PRIOR SURGERIES, PROCEDURES, AND PREGNANCIES:

(PLEASE LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD)

DATE	SURGERY / PROCEDURES	DATE	SURGERY / PROCEDURES

FAMILY MEDICAL HISTORY:

CHECK IF ADOPTED: ☐

	LIVING Y/N	AGE	MEDICAL CONDITIONS	EXCESS WEIGHT Y/N
MOTHER				
FATHER				
SIBLING				
SIBLING				
SIBLING				
SIBLING				

SOCIAL HISTORY:

PLEASE CHECK THE BOX THAT BEST APPLIES TO YOU

TOBACCO USE			
☐ CURRENT EVERYDAY SMOKER	☐ CURRENT SOME DAYS SMOKER	☐ FORMER SMOKER	☐ NON-SMOKER
HOW MANY PACKS PER DAY?	HOW MANY YEARS HAVE YOU BEEN SMOKING?		QUIT DATE:
SMOKELESS TOBACCO USE			
☐ CURRENT USER	☐ FORMER USER	QUIT DATE:	☐ NEVER USED
ALCOHOL USE			
HOW MANY SERVINGS OF ALCOHOL DO YOU USUALLY HAVE PER WEEK?		☐ 0 ☐ 1 - 2 ☐ 3 - 4 ☐ 5 – 7 ☐ 8-13 ☐ 14+	
☐ BEER	☐ WINE	☐ MIXED DRINK	☐ LIQUOR
ILLICIT DRUG USE			
DO YOU HAVE A HISTORY OF ILLICIT DRUG USE? ☐ YES ☐ NO			
SEXUAL ACTIVITY			
HAVE YOU BEEN SEXUALLY ACTIVE IN THE PAST 12 MONTHS?	☐ YES ☐ NO		
WHO CURRENTLY LIVES IN YOUR HOUSEHOLD?			

PERSONAL WEIGHT LOSS HISTORY:

PLEASE CHECK ANY OF THE FOLLOWING COMMERICAL PROGRAMS YOU HAVE USED				
☐ ATKINS / KETO / LCHF	☐ HERBALIFE	☐ JENNY CRAIG	☐ NEW DIRECTIONS	☐ NUTRISYSTEM
☐ OPTIFAST / MEDIFAST	☐ WHOLE 30	☐ SOUTH BEACH DIET	☐ WEIGHT WATCHERS	OTHER:
PLEASE CHECK ANY OF THE FOLLOWING WEIGHT LOSSS MEDICATIONS YOU HAVE USED				
☐ ACUTRIM	☐ AMPHETAMINES	☐ BELVIQ	☐ CONTRAVE	☐ DEXATRIM
☐ FEN-PHEN	☐ GREEN TEA	☐ LAXATIVES	☐ MERIDIA	☐ PHENTERMINE
☐ REDUX	☐ SAXENDA	☐ TOPAMAX	☐ XENICAL	☐ OTHER:
PLEASE CHECK ANY OF THE FOLLOWING BEHAVIORAL INTERVENTIONS THAT YOU HAVE USED				
BEHAVIOR MODIFICATION				
☐ REGISTERED DIETITIAN	☐ ACCUPUNCTURE	☐ HYPNOSIS	☐ OA	☐ PSYCHOTHERAPY
☐ TOPS	☐ TREVOSE	☐ OTHER:		
EXERCISE PROGRAMS				
☐ GYM MEMBERSHIP	☐ BEACHBODY PROGRAM	☐ CROSSFIT	☐ PERSONAL TRAINER	
☐ OTHER(S):				

Are you interested in discussing a nutrition plan at your 1st visit? ☐ YES ☐ NO ☐ MAYBE

Are you interested in discussing medications that can help with weight loss? ☐ YES ☐ NO ☐ MAYBE

Are you interested in discussing surgical options? ☐ YES ☐ NO ☐ MAYBE

Are you interested in discussing meal replacements? ☐ YES ☐ NO ☐ MAYBE

Are you interested in discussing weight loss supplements? ☐ YES ☐ NO ☐ MAYBE

PERSONAL WEIGHT HISTORY:

AT WHAT WEIGHT DO YOU FEEL HEALTHY? ___________ LBS **WHEN DID YOU LAST WEIGH THAT AMOUNT? ______________________**

WHEN DID YOU START HAVING TROUBLE MANAGING YOUR WEIGHT? ____

AGE AND WEIGHT OF 1ST WEIGHT LOSS ATTEMPT: ____

WEIGHT TREND IN THE PAST YEAR: ☐STABLE ☐ INCREASING ☐ DECREASING

LOWEST ADULT WEIGHT: __________ LBS AGE: ___________ HIGHEST ADULT WEIGHT: __________ LBS AGE: _________

DID YOU HAVE EXCESS WEIGHT AS A CHILD? ☐YES ☐ NO WEIGHT AT AGE 18: ____________ LBS

GREATEST WEIGHT LOSS: _____________________________ HOW: ________________________ WHEN: _______________________

WHY DID YOU STOP THAT PLAN? ____

HOW MANY TIMES HAVE YOU LOST MORE THAN 10 POUNDS? ☐ 0 ☐ 1 – 2 ☐3 – 5 ☐6 – 9 ☐10+

HOW MANY TIMES HAVE YOU GAINED 10 OR MORE POUNDS IN 3 MONTHS? ☐ 0 ☐ 1 – 2 ☐3 – 5 ☐6 – 9 ☐10+

LIST ANY LIFE EVENTS RELATED TO THE TIMES YOU GAINED WEIGHT QUICKLY____

FOOD PATTERNS:

PLEASE ANSWER THE FOLLOWING QUESTIONS BASED ON A TYPICAL DAY

WHAT TIME DO YOU FIRST EAT/DRINK ANYTHING FOR THE DAY?		DO YOU TRACK YOUR FOOD INTAKE? ☐ YES ☐ NO If yes, how?	
WHAT TIME ARE YOU FINISHED EATING/DRINKING FOR THE DAY?		CURRENT FOOD PLAN, IF ANY?	
HOW MANY MEALS DO YOU EAT PER DAY?		LIST ANY FOOD INTOLERANCES:	
HOW MANY SNACKS TO YOU HAVE PER DAY?		WHO DOES THE GROCERY SHOPPING?	
WHAT ARE YOUR MOST COMMON SNACKS?		WHO PREPARES MEALS AT HOME?	
HOW MANY DAYS PER WEEK DO YOU EAT AFTER DINNER?		HOW MANY MEALS PER WEEK ARE NOT PREPARED AT HOME?	
HOW MANY DAYS PER WEEK DO YOU EAT IN THE MIDDLE OF THE NIGHT?			
DO YOU TEND TO GRAZE INSTEAD OF HAVING MEALS? ☐ YES ☐ NO			
WHAT DID YOU EAT AND DRINK YESTERDAY?		IS THIS TYPICAL?	☐ YES ☐ NO
BREAKFAST	LUNCH	DINNER	SNACK(s)

HOW MANY SERVINGS OF FOLLOWING BEVERAGES DO YOU DRINK PER DAY?	
WATER	REGULAR SODA (12 oz.)
SELTZER	DIET DRINKS (12 oz.)
COFFEE SWEETENED YES NO	CRYSTAL LIGHT
TEA SWEETENED YES NO	SPORTS DRINK (20 oz.)
MILK COW (SKIM, 1%, 2%, WHOLE) (8 oz.)	ENERGY DRINKS
MILK ALTERNATIVES, ALMOND, SOY (8oz.)	FRUIT JUICE (4 oz.)
PROTEIN DRINKS/SHAKES	SMOOTHIES
ALCOHOLIC BEVERAGES	OTHER

ON AN AVERAGE DAY, LIST THE NUMBER OF SERVINGS YOU HAVE OF EACH:				
VEGETABLES ________	FRUITS __________	PROTEINS __________	STARCHES _________	JUNK FOOD _____________

Patient Initials & Date:___________________________

Eating Behaviors: CHECK all that apply

WHEN I AM NOT HUNGRY, I MAY STILL EAT… WHEN I AM: BORED IRRITABLE LONELY TIRED SAD STRESSED CELEBRATING IN ORDER TO: STAY AWAKE PROCRASTINATE SOCIALIZE (PARTIES/ WORK EVENTS) BECAUSE FOOD IS: AVAILABLE FREE OFFERED CONVENIENT
I STOP EATING WHEN: SATISFIED FULL OVERFULL PLATE/CONTAINER IS EMPTY
DO YOU THINK YOU EAT TOO QUICKLY? YES NO
I EAT WHILE: DRIVING WORKING COOKING READING WATCHING TV ON PHONE ON COMPUTER/TABLET
CHECK ALL STATEMENTS THAT APPLY TO YOU: I ALWAYS FEEL HUNGRY I NEVER FEEL HUNGRY I AM NEVER FULL I FORGET TO EAT I SKIP MEALS
WHAT FOODS, IF ANY, DO YOU CRAVE? HOW OFTEN DO YOU GET FOOD CRAVINGS?
DO YOU EVER THINK YOU MAY BE ADDICTED TO CERTAIN FOODS? YES NO IF YES, WHICH FOODS?
IN THE PAST 3 MONTHS, HOW OFTEN, DID YOU HAVE AN EPISODE OF EXCESSIVE OVEREATING (EATING SIGNIFICANTLY MORE THAN OTHERS IN THE SAME SITUATION)? NEVER 1-2 TIMES DAILY WEEKLY MONTHLY

PLEASE SHARE ANY OTHER INSIGHTS ABOUT YOUR LIFESTYLE PATTERNS OR WEIGHT HISTORY THAT YOU THINK ARE IMPORTANT FOR US TO KNOW:

____

____

____

ACTIVITY PATTERNS

WHAT IS YOUR CURRENT STRESS LEVEL? LOW MEDIUM HIGH			
WHAT FACTORS CONTRIBUTE TO YOUR STRESS?			
WHAT HOBBIES DO YOU ENJOY?	HOW OFTEN DO YOU ENJOY THEM? DAILY WEEKLY MONTHLY		
HOW DO YOU RELAX?			
DO YOU USE AN ACTIVITY TRACKER? ☐ YES ☐ NO IF YES WHAT TYPE? HOW MANY STEPS DO YOU GET PER DAY?			
DESCRIBE YOUR LEVEL OF ACTIVIY AT WORK:	☐ SEDENTARY	☐ MODERATELY ACTIVE	☐ STRENUOUS
DESCRIBE YOUR LEVEL OF ACTVITY AT HOME:	☐ SEDENTARY	☐ MODERATELY ACTIVE	☐ I NEVER SIT DOWN
HOURS OF WORK SCREEN TIME PER DAY?	HOURS OF LEISURE SCREEN (TV/TABLET/PHONE) TIME PER DAY?		
DO YOU CURRENTLY EXERCISE? ☐ YES ☐ NO IF YES, HOW OFTEN AND WHAT TYPE?			
DESCRIBE YOUR LIMITATIONS TO EXERCISE, IF ANY:			
HOW MANY HOURS OF SLEEP DO YOU GET A NIGHT?	IS YOUR SLEEP RESTFUL? ☐ YES ☐ NO		
IF SLEEP IS NOT RESTFUL, DO YOU HAVE TROUBLE ☐ FALLING ASLEEP ☐ STAYING ASLEEP ☐ BOTH			

REVIEW OF SYSTEMS:

PLEASE CHECK THE BOX NEXT TO ANY CONDITION YOU HAVE EXPERIENCED IN THE PAST 3 MONTHS

CONSTITUTIONAL

- ☐ ACTIVITY CHANGE
- ☐ APPETITE CHANGE
- FATIGUE
- ☐ HEREDITARY DEFECTS

ENT

- ☐ HEARING LOSS
- ☐ SORE THROAT OR VOICE CHANGE
- ☐ TROUBLE SWALLOWING
- ☐ SWOLLEN GLANDS IN THE NECK

EYES

- ☐ BLURRED VISION
- ☐ DOUBLE VISION
- ☐ ITCHY EYES
- ☐ EYE PAIN

RESPIRATORY

- ☐ FREQUENT COUGHING
- ☐ SHORTNESS OF BREATH AT REST
- ☐ SHORTNESS OF BREATH WHILE WALKING
- ☐ SNORING
- ☐ WHEEZING

CARDIOVASCULAR

- ☐ CHEST PAINS/ANGINA
- ☐ SUDDEN HEARTBEAT CHANGES
- ☐ SWELLING OF FEET, ANKLES, OR HANDS
- ☐ SYNCOPE (PASSING OUT)

GASTROINTESTINAL

- ☐ ABDOMINAL BLOATING
- ☐ CHANGE IN BOWEL MOVEMENTS
- ☐ NAUSEA OR VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ BLOOD IN STOOL
- ☐ REFLUX OR HEARTBURN
- ☐ STOMACH PAIN

ENDOCRINE

- ☐ EXCESSIVE THIRST
- ☐ HEAT INTOLERANCE
- ☐ COLD INTOLERANCE
- ☐ EXCESSIVE HUNGER
- ☐ FLUCTUATING BLOOD SUGARS

GENITOURINARY

- ☐ FREQUENT URINATION
- ☐ BURNING OR PAINFUL URINATION
- ☐ BLOOD IN URINE
- ☐ CHANGE OF FORCE OR STRAIN
- ☐ DECREASED LIBIDO
- ☐ MALE: ERECTILE DYSFUNCTION
- ☐ FEMALE: PAIN WITH PERIODS
- ☐ FEMALE: IRREGULAR PERIODS
- ☐ FEMALE: VAGINAL DISCHARGE

MUSCULOSKELETAL

- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS OR SWELLING
- ☐ WEAKNESS OF MUSCLES/JOINTS
- ☐ MUSCLE PAIN OR CRAMPS
- ☐ BACK PAIN
- ☐ COLD EXTREMITIES
- ☐ DIFFICULTY IN WALKING

SKIN

- ☐ RASH
- ITCHING, OR DRY SKIN
- ☐ CHANGE IN SKIN COLOR
- ☐ CHANGE IN HAIR OR NAILS
- ☐ VARICOSE VEINS
- ☐ RAISED SCARS
- ☐ BREAST PAIN
- ☐ BREAST LUMP
- ☐ BREAST DISCHARGE
- ☐ HAIR LOSS
- ☐ ACNE
- ☐ SKIN TAGS

ALLERGY IMMUNOLOGIC

- ☐ FREQUENT ANTIBIOTIC USE (2 OR MORE TIMES A YEAR)
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ FOOD INTOLERANCES
- ☐ IMMUNOCOMPROMISED

NEUROLOGICAL

- ☐ FREQUENT/RECURRING HEADACHES
- ☐ LIGHTHEADED OR DIZZY
- ☐ CONVULSIONS OR SEIZURES
- ☐ NUMBNESS/TINGLING SENSATIONS
- ☐ TREMORS
- ☐ PARALYSIS

HEMATOLOGIC/LYMPHATIC

- ☐ EASILY BRUISE OR BLEED
- ☐ ANEMIA
- ☐ ENLARGED GLANDS
- ☐ BLEEDING DISORDER
- ☐ ACUTE INFECTION

PSYCHIATRIC

- ☐ MEMORY LOSS OR CONFUSION
- ☐ NERVOUSNESS
- ☐ MOOD PROBLEMS
- ☐ SLEEP PROBLEMS
- ☐ PSYCHIATRIC PROBLEMS