

PROGRESSIVE MEDICAL GROUP, INC.
MEDICAL WEIGHT MANAGEMENT / WEIGHT LOSS INTAKE FORM

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PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ **Age:** _____

Phone: _____

Email: _____

Address: _____

City/State/ZIP: _____

Preferred Pharmacy: _____

Pharmacy Phone: _____

WEIGHT MANAGEMENT GOALS

What is your primary reason for seeking medical weight management?

- ☐ Weight loss
- ☐ Improve overall health
- ☐ Improve blood pressure
- ☐ Improve blood sugar
- ☐ Improve cholesterol
- ☐ Improve mobility
- ☐ Improve sleep
- ☐ Reduce joint pain
- ☐ Improve energy

- ☐ Prevent/manage chronic disease
☐ Other: _____

What is your personal weight-loss goal?

Goal weight: _____ lbs

Desired weight loss: _____ lbs

Target timeframe, if any: _____

What would successful weight management mean to you?

WEIGHT HISTORY

Current weight: _____ lbs

Height: _____

Highest adult weight: _____ lbs

Lowest adult weight after age 18: _____ lbs

When did you first begin having difficulty maintaining your weight?

Recent weight changes

- ☐ Stable
☐ Gradual weight gain
☐ Rapid weight gain
☐ Weight loss

Approximate change: _____ lbs over _____ months

Have you previously lost a significant amount of weight?

☐ No ☐ Yes

Amount lost: _____ lbs

How did you lose the weight?

Did you regain the weight? ☐ No ☐ Yes

PREVIOUS WEIGHT-LOSS ATTEMPTS

Please check all that apply:

- ☐ Calorie restriction
- ☐ Low-carbohydrate diet
- ☐ Keto diet
- ☐ Mediterranean diet
- ☐ Intermittent fasting
- ☐ Commercial weight-loss program
- ☐ Personal trainer/exercise program
- ☐ Nutritionist/dietitian
- ☐ Prescription weight-loss medication
- ☐ GLP-1 medication
- ☐ Bariatric surgery
- ☐ Other: _____

What worked best for you?

What made previous attempts difficult?

- ☐ Hunger
 - ☐ Food cravings
 - ☐ Busy schedule
 - ☐ Stress
 - ☐ Lack of support
 - ☐ Cost
 - ☐ Side effects
 - ☐ Medication stopped working
 - ☐ Difficulty exercising
 - ☐ Difficulty maintaining diet
 - ☐ Other: _____
-

CURRENT DIET AND NUTRITION

How many meals do you typically eat per day?

☐ 1 ☐ 2 ☐ 3 ☐ 4+

Snacks per day:

☐ None ☐ 1 ☐ 2 ☐ 3+

Typical breakfast:

Typical lunch:

Typical dinner:

Common snacks:

Beverages

Water: Approximately _____ oz/day

Soda: ☐ None ☐ Occasionally ☐ Daily

Juice: ☐ None ☐ Occasionally ☐ Daily

Sweetened beverages: ☐ None ☐ Occasionally ☐ Daily

Other: _____

Do you frequently experience:

- ☐ Excessive hunger
- ☐ Food cravings
- ☐ Emotional eating
- ☐ Binge eating
- ☐ Eating late at night
- ☐ Eating when stressed

- ☐ Skipping meals
 - ☐ None
-

PHYSICAL ACTIVITY

Current exercise/activity

- ☐ None
- ☐ Walking
- ☐ Running
- ☐ Strength training
- ☐ Cycling
- ☐ Swimming
- ☐ Gym
- ☐ Other: _____

Days per week: _____

Average duration: _____ minutes

Physical limitations affecting exercise:

- ☐ None
 - ☐ Back pain
 - ☐ Knee pain
 - ☐ Hip pain
 - ☐ Arthritis
 - ☐ Shortness of breath
 - ☐ Balance problems
 - ☐ Other: _____
-

MEDICAL HISTORY

Have you ever been diagnosed with:

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Prediabetes

- ☐ High cholesterol
 - ☐ Heart disease
 - ☐ Heart failure
 - ☐ Heart attack
 - ☐ Stroke/TIA
 - ☐ Sleep apnea
 - ☐ Fatty liver/liver disease
 - ☐ Kidney disease
 - ☐ Thyroid disease
 - ☐ Gallbladder disease/gallstones
 - ☐ Pancreatitis
 - ☐ Gastrointestinal disease
 - ☐ Depression
 - ☐ Anxiety
 - ☐ Eating disorder
 - ☐ Other: _____
-

MEDICATION HISTORY

Current prescription medications:

Vitamins/supplements:

Have you previously taken a GLP-1 or other weight-loss medication?

☐ No ☐ Yes

If yes, please complete:

Medication: _____

Dose: _____

Approximate dates used: _____

Amount of weight lost: _____ lbs

Reason discontinued: _____

Side effects: _____

Other prescription weight-loss medications previously used:

GLP-1 / WEIGHT-LOSS MEDICATION SCREENING

Please notify your provider if you have a history of any of the following:

- ☐ Pancreatitis
- ☐ Gallstones/gallbladder disease
- ☐ Severe gastrointestinal disease
- ☐ Severe or persistent vomiting
- ☐ Delayed stomach emptying/gastroparesis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Diabetic retinopathy
- ☐ Previous reaction to a GLP-1 medication
- ☐ Other significant medication reaction

Additional information:

THYROID / ENDOCRINE HISTORY

History of thyroid disease: ☐ No ☐ Yes

History of thyroid nodules: ☐ No ☐ Yes

History of thyroid cancer: ☐ No ☐ Yes

History of endocrine tumors: ☐ No ☐ Yes

Previous thyroid surgery: ☐ No ☐ Yes

Current thyroid medication: ☐ No ☐ Yes

If yes, explain:

FAMILY HISTORY

Please check if a close family member has had:

☐ Diabetes

☐ Obesity

☐ Heart disease

☐ High blood pressure

☐ High cholesterol

☐ Thyroid disease

☐ Thyroid cancer

☐ Endocrine tumors

☐ Pancreatitis

☐ Other: _____

WOMEN'S HEALTH

Are you currently pregnant?

☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Are you breastfeeding?

☐ No ☐ Yes ☐ Not applicable

Are you planning pregnancy?

☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Current birth control method, if applicable:

Last menstrual period: _____

I understand that pregnancy status may affect eligibility for certain weight-management medications and treatments.

SLEEP

Average hours of sleep per night:

_____ hours

Do you snore?

☐ No ☐ Yes

Has anyone observed pauses in your breathing during sleep?

☐ No ☐ Yes

Do you feel excessively tired during the day?

☐ No ☐ Yes

Have you been diagnosed with sleep apnea?

☐ No ☐ Yes

MENTAL HEALTH & EATING BEHAVIOR

Have you experienced:

- ☐ Depression
- ☐ Anxiety
- ☐ Significant stress
- ☐ Emotional eating
- ☐ Binge eating
- ☐ Loss of control over eating

- ☐ Eating disorder
☐ None

Are you currently receiving mental-health treatment?

- ☐ No ☐ Yes

Current mental-health medications:

SOCIAL HISTORY

Smoking/nicotine:

- ☐ Never ☐ Former ☐ Current

Alcohol:

- ☐ None ☐ Occasional ☐ Regular

Recreational drug use:

- ☐ No ☐ Yes

Occupation: _____

Do any of the following make weight management difficult?

- ☐ Food insecurity
☐ Transportation problems
☐ Cost of healthy food
☐ Work schedule
☐ Family responsibilities
☐ Limited access to exercise
☐ Stress
☐ None
☐ Other: _____

BASELINE MEASUREMENTS

Height: _____

Weight: _____

BMI: _____

Waist circumference: _____ inches

Blood pressure: _____ / _____

Pulse: _____

Date: _____

LABORATORY / HEALTH INFORMATION

If available, please provide recent results:

A1C: _____ Date: _____

Fasting glucose: _____ Date: _____

Lipid panel: _____

TSH: _____ Date: _____

Kidney function/creatinine/eGFR: _____

Liver enzymes: _____

Other relevant laboratory results:

PATIENT GOALS & PLAN

What are your top three health goals?

1. _____

2. _____

3. _____

What type of support would be most helpful?

- ☐ Medication management
 - ☐ Nutrition counseling
 - ☐ Exercise guidance
 - ☐ Behavioral support
 - ☐ Regular weight monitoring
 - ☐ Combination approach
 - ☐ Other: _____
-

PATIENT ACKNOWLEDGMENT

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

I understand that completion of this intake form **does not guarantee eligibility for weight-loss medication or treatment.**

I understand that my provider will review my medical history, medications, physical examination, laboratory information, treatment goals, and other relevant factors before recommending a treatment plan.

I understand that weight-management treatment may include lifestyle modification, nutrition and physical-activity counseling, behavioral strategies, medication when clinically appropriate, and/or referral to another healthcare professional.

I understand that medications have potential risks, side effects, contraindications, and drug interactions. A separate medication-specific informed consent may be required before treatment is initiated.

I agree to notify Progressive Medical Group of changes in my health, medications, pregnancy status, allergies, or other relevant medical information.

Patient/Legal Representative Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Provider: ☐ Jasvir Kaur Kailey, FNP-BC

☐ Roland O. Willock, MD

Initial Weight: _____ lbs

Initial BMI: _____

Waist Circumference: _____

BP: _____ / _____

Weight-management diagnosis/assessment:

Labs ordered/reviewed: ☐ Yes ☐ No

Medication reconciliation: ☐ Completed

Contraindications/precautions reviewed: ☐ Yes ☐ No

Treatment plan:

☐ Lifestyle modification

☐ Nutrition counseling

☐ Exercise counseling

☐ Medication

☐ GLP-1 medication evaluation

☐ Laboratory testing

☐ Follow-up

☐ Referral

☐ Other: _____

Follow-up date: _____

Provider Signature: _____

Date: _____