METHODIST PHYSICIANS CLINIC

WEIGHT LOSS ASSESSMENT RECORD

1. PATIENT INFORMATION

Name: _____ Age:_____ D.O.B._____ Race:_____
Level of Education: _____Marital Status (circle): Single Married Widowed Divorced
Occupation: _____ Work Hours:_____
Provider's Name:_____

2. GENERAL MEDICAL HISTORY

Present health status: Excellent Good Fair Poor
Are you currently experiencing any pain? ☐ No ☐ Yes If yes, what type?_____
Date:_____
Total Cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____
A1C:_____ Blood Pressure: _____
Allergies: _____
List any medical conditions: _____
_____
Medications you are currently taking: _____
_____
List surgeries and/or hospitalizations in the past year: _____
_____
Smoking History: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker _____
List any family history of diabetes, heart disease, high blood pressure or obesity:_____
_____

3. WEIGHT LOSS HISTORY

Please list any weight loss programs you have used before:_____
_____
Were any of them successful? ☐ No ☐ Yes If yes, how many pounds did you lose?_____
How long did you maintain this weight loss?_____

4. PHYSICAL ACTIVITIES/HABITS

Do you exercise? ☐ Yes ☐ No If no, are you willing to start? ☐ Yes ☐ No

If yes, **Type**	**Length of time**	**Intensity (circle)**			**# Times/Week**
_____	_____	*Light*	*Medium*	*Heavy*	_____
_____	_____	*Light*	*Medium*	*Heavy*	_____

Have you ever been advised by a medical provider to limit your exercise in any way? ☐ Yes ☐ No
If yes, what are the limitations?_____

5. SOCIAL HISTORY

Do you have problems reading? ☐ Yes ☐ No Do you have problems hearing? ☐ Yes ☐ No
Number in household? _____ Relationship/s:_____
Besides weight loss, are there other changes you are making in your life now? ☐ Yes ☐ No
If yes, what? (*job, divorce, moving*):_____
How motivated are you to work at weight loss? (circle) Very Motivated Motivated Not Motivated
What is your motivation to lose weight?:
☐ Life threatening health issues ☐ Better appearance ☐ Significant others in my life want me to
☐ Better overall health ☐ Doctor told me to ☐ To be able to be more physically active

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____

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PERMANENT PART OF MEDICAL RECORD

NMHS-1595
Rev. 5/2025

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6. NUTRITION HISTORY

Weight:_____ Height:_____
Weight changes in the last year? Increased Weight:_____lb. Decreased Weight:_____lb.

1. Do you skip meals? ☐ No ☐ Yes If yes, which meals?_____
   How often?_____
2. Do you do your own grocery shopping? ☐ Yes ☐ No
3. Who does the cooking in your house? ☐ Self ☐ Spouse ☐ Other_____
4. Do you eat out? ☐ No ☐ Yes If yes, how often?_____ Where?_____
5. Do you drink alcohol? ☐ No ☐ Yes If yes, number of drinks: ☐ per week or ☐ per day is = _____
6. Who does the cooking? _____

In the space provided, record what you typically eat including type and amount of food.

Example:	*Cereal-Cheerios - 1 Cup* *Milk – Skim - 1 Cup* *Toast - 2 slices*
Meal Times	**Food Eaten and Amount**
Breakfast Time_____	
Snack Time_____	
Lunch Time_____	
Snack Time_____	
Dinner Time_____	
Snack Time_____	

Patient Label
NAME:_____DOB:_____
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