

PROGRAM Option: VLCD (Shake Only) LCD Phase 2/Maintenance
 DPP/Healthy Lifestyle Nutrition Counseling

SITE: Kirmayer Lawrence Medwest

Class Day/Time Preference: _____

The University of Kansas Weight Management Programs

Last Name First Name Today's Date

Address City State Zip Code

Age: _____ Date of Birth: _____ Gender: M F

Which of the following would you say best represents your race?

_____ White _____ Native Hawaiian / Pacific Islander _____ Multiracial
_____ Black or African American _____ Native American / Alaska Native
_____ Asian _____ Other / Unknown

Which of the following would you say best represents your ethnicity?

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Other or Unknown

The above information is collected for aggregate descriptive purposes only

Preferred Phone: () _____ Email: _____

WEIGHT HISTORY

Current Weight _____ Height _____ Lowest Adult Weight _____ Highest Adult Weight _____

Previous weight reduction attempts/methods: _____

Have you ever taken any prescription weight loss medications? If yes, what and when? _____

Physical Activity

Do you have any physical restrictions to activity? yes no Explain: _____

MEDICAL HISTORY

Do you have or have you ever had any of the following medical conditions?

		Date/Year of Diagnosis	Describe the Problem
High Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Kidney Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____

Liver Problems yes no _____

Psychiatric Problems yes no _____

Sleep Apnea yes no _____

Have you had any surgery in the past 12 months? yes no
 If yes, please describe the surgery: _____

Allergies

Have you ever had a reaction to:			If yes, please explain reaction:
Milk/Dairy products	Y	N	_____
Eggs	Y	N	_____
Soy products	Y	N	_____
Corn products	Y	N	_____
Wheat gluten	Y	N	_____
Other food	Y	N	_____

Reproductive (WOMEN ONLY)

Are you currently pregnant? yes no

Were you pregnant within the past 6 months? yes no

Do you plan to become pregnant in the next 18 months? yes no

Are you currently breast feeding? yes no

DIABETES HISTORY (If applicable)

Diabetes Onset

Year of Diagnosis: _____ Most Recent Hgb A1c level: _____ Date Taken: _____

Current Managing Physician: _____

Address: _____ Phone #: _____

Blood Sugars

Do you currently perform home blood sugar checks? No Yes
 If so, how often? _____ Recent levels: _____

Have you ever experienced hypoglycemia (low blood sugar): No (skip 1-3) Yes (answer below)

- 1) What are your personal signs and symptoms of hypoglycemia? _____

- 2) What has been your usual treatment for hypoglycemia? _____

- 3) Do you have hypoglycemia without warning symptoms? No Yes

Diabetes Complications

Has your diabetes ever resulted in hospitalization, diabetic coma or DKA/ketoacidosis?
 No Yes _____

The University of Kansas Physicians

3901 Rainbow Blvd. Kansas City, KS 66160

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name: _____

KUMC#: _____

Date: _____ DOB: _____

Primary Care Doctor _____

Phone(____) _____

Address _____

Referring Doctor _____

Phone(____) _____

Address _____

Reason for Visit:

Medical History:

• Patient medical history:	Previous Hospitalizations/Surgeries/Serious Injuries	When?
Diabetes	Yes No	_____
Hypertension	Yes No	_____
Cancer	Yes No	_____
Stroke	Yes No	_____
Heart trouble	Yes No	_____
Arthritis/gout	Yes No	_____
Convulsions	Yes No	_____
Bleeding tendency	Yes No	_____
Acute infections	Yes No	_____
Sexual disease	Yes No	_____
Birth defects	Yes No	_____
Thyroid problems	Yes No	_____
Osteoporosis	Yes No	_____
Vision problems	Yes No	_____
Hearing problems	Yes No	_____
Ulcer/stomach problems	Yes No	_____
Back pain	Yes No	_____
Other:		_____

Medications:

Allergies:

• Patient social history:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit: _____ Current packs /day: _____

Use of drugs: Never: _____ Type / frequency: _____

Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Air-borne particles: _____ Noise: _____

Occupation/Work Environment: Please describe: _____

Do you have a living will or advanced directive? Yes _____ No _____

• Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems: Please indicate any personal history below:

• **CONSTITUTIONAL SYMPTOMS**

Good general health lately..... Yes No
 Recent weight change..... Yes No
 Decreased appetite..... Yes No
 Fever/nightsweats..... Yes No
 Fatigue/weakness..... Yes No
 Headaches..... Yes No

• **EYES**

Eye disease or injury..... Yes No
 Wear glasses/contact lenses..... Yes No
 Blurred or double vision..... Yes No
 Glaucoma/cataracts..... Yes No

• **EARS/NOSE /THROAT**

Hearing loss or ringing..... Yes No
 Earaches or drainage..... Yes No
 Chronic sinus problems..... Yes No
 Nose bleeds..... Yes No
 Mouth sores..... Yes No
 Sore throat or voice change..... Yes No
 Swollen glands in neck..... Yes No

• **CARDIOVASCULAR**

Heart trouble..... Yes No
 Chest pain or angina pectoris..... Yes No
 Palpitation..... Yes No
 Shortness of breath with walking or lying flat. Yes No
 Swelling of feet, ankles or hands..... Yes No

• **RESPIRATORY**

Chronic or frequent coughs..... Yes No
 Spitting up blood..... Yes No
 Shortness of breath..... Yes No
 Asthma or wheezing..... Yes No

• **GASTROINTESTINAL**

Loss of appetite..... Yes No
 Change in bowel movements..... Yes No
 Nausea or vomiting..... Yes No
 Frequent diarrhea..... Yes No
 Painful bowel movements or constipation..... Yes No
 Rectal bleeding or blood in stool..... Yes No
 Abdominal pain..... Yes No
 Ulcer (stomach or duodenal)..... Yes No

• **GENITOURINARY**

Frequent urination..... Yes No
 Burning or painful urination..... Yes No
 Awaken at night to urinate..... Yes No
 Blood in urine..... Yes No
 Change in force of stream when urinating..... Yes No
 Incontinence or dribbling..... Yes No
 Sores or discharge..... Yes No
 Kidney stones..... Yes No
 Sexual difficulty..... Yes No
 Male - testicle pain/lumps..... Yes No
 Female - pain with periods..... Yes No
 Female - irregular periods..... Yes No
 Female - vaginal discharge..... Yes No
 Female - # of pregnancies..... _____
 Female - # of miscarriages:..... _____
 Female - date of last pap smear:..... _____

• **MUSCULOSKELETAL**

Joint pain..... Yes No
 Joint stiffness or swelling..... Yes No
 Weakness of muscles or joints..... Yes No
 Muscle pain or cramps..... Yes No
 Back pain..... Yes No
 Difficulty in walking..... Yes No

• **INTEGUMENTARY (skin, breast)**

Rash or itching..... Yes No
 Change in skin color..... Yes No
 Change in hair or nails..... Yes No
 Varicose veins..... Yes No
 Breast pain..... Yes No
 Breast lump..... Yes No
 Breast discharge..... Yes No

• **NEUROLOGICAL**

Frequent or recurring headaches..... Yes No
 Light headed or dizzy..... Yes No
 Convulsions or seizures..... Yes No
 Numbness or tingling sensations..... Yes No
 Shakes..... Yes No
 Paralysis..... Yes No
 Stroke..... Yes No
 Head injury..... Yes No

• **PSYCHIATRIC**

Memory loss or confusion..... Yes No
 Nervousness..... Yes No
 Depression..... Yes No
 Difficulty sleeping..... Yes No

• **ENDOCRINE**

Glandular or hormone problem..... Yes No
 Thyroid disease..... Yes No
 Diabetes (*insulin or non insulin - circle one*)..... Yes No
 Excessive thirst or urination..... Yes No
 Heat or cold intolerance..... Yes No

• **HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts..... Yes No
 Bleeding or bruising tendency..... Yes No
 Anemia..... Yes No
 Blood clots..... Yes No
 Blood transfusion..... Yes No
 Enlarged glands..... Yes No

• **ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to: Yes No
 Penicillin or other antibiotics..... Yes No
 Morphine, Demerol, or other narcotics..... Yes No
 Novocaine or other anesthetics..... Yes No
 Aspirin or other pain remedies..... Yes No
 Tetanus antitoxin or other serums..... Yes No
 Iodine, merthiolate or other antiseptic..... Yes No
 Other drugs/medications: _____
 Known food allergies: _____
 Environmental allergies: _____

Reviewed by: _____

Date: _____