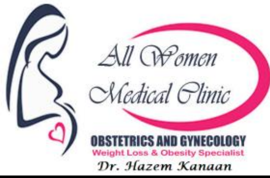

Hazem Kanaan, D.O., FACOOG, Dip-ABOM
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Detailed Weight History Intake

NAME: ______________________________ DATE: _____/_________/_________

ADDRESS: ______________________________ BIRTH DATE: _____/_________/__________

CITY: ______________________________ HOME TEL: (   ) ______________________

STATE/ZIP ______________________________ WORK TEL: (   ) ______________________

EMPLOYER: ______________________________ INSURANCE: ______________________

NAME OF SPOUSE/PARTNER ______________________________ REFERRED BY: ______________________

Current Height:__________ Current Weight:____________
Lowest adult weight? _______________ What year?________________
Highest weight?________________ What year?______________________ Goal Weight?_________________

How much Weight (lbs) have you gained over the following most recent time periods?

6 months	1 year	2 year	3 year	5 year	10 year

Why are you trying to achieve weight loss?

When did you started gaining unhealthy weight? (can you relate it to a reason)

What do you think the main cause of your weight gain?

Have you tired weight loss programs or over the counter meds? Any were successful?

Name the most effective way for you to lose weight?

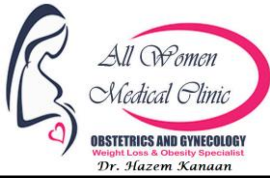
What is your biggest obstacle for achieving your weight goal?

When was the last time you had blood work up?

Are you interested in meal replacements? Yes _____ No _____ If yes: Some_____ or All_____

Have you had bariatric surgery? Are you planning on getting one?

In a typical week, how many of the following you skip and why?
Breakfast: __________ Lunch:__________ Dinner: _________ Why?



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In a typical week how many meals do you eat non-homemade food? ___________

Typically, which restaurants do you visit for eat out or take out? ____

Do you frequently eat overnight? NO ______ ; YES_______ (I eat overnight)

What time is your typical last consumption of food? ________, When do you go to sleep? __________

Are you a stress eater? NO _______ ; YES ________ (I am a stress eater)

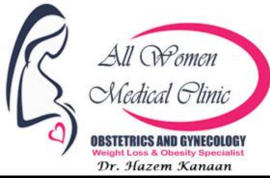
Do you always feel hungry? NO _______ ; YES________ (I am always hungry)

When you start eating are you able to stop eating as soon as you start feeling full? NO _____ ; YES _____

Typically, how long does it take you to finish your lunch or dinner? _______________ min
What kind of drink do you consume when eating? Water; Alcohol; Soda; Diet Soda; Mixers; Fresh squeeze

Are you interested in appetite suppressant? NO ____, YES ____(I am interested in appetite suppressant)

Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)					
Meal	**Main Dishes**	**Side dishes**	**Desserts**	**Drinks**	**Eating Out / Restaurants**
Breakfast					# breakfasts out/week & where?
Morning Snacks					
Lunch					# lunches out/week & where?
Afternoon Snacks					
Dinner					# dinners out/week & where?
Evening Snacks					



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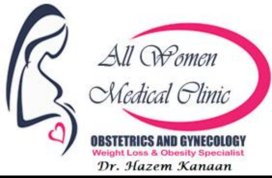
Activity and Exercise	
Please select your current activity level (select only one of the options)	☐ Inactive - no regular physical activity with a sit down sedentary job ☐ Moderate Activity - i.e. occasionally walk, jog, run, bike, golf, tennis ☐ Heavy Activity - regular exercise at least 3x per week ☐ Vigorous Activity - extensive exercise > 60 min at least 4x/week
Outside of work and working in the home, please describe what physical activity you do and how often:	
Do you do any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)?	
What limits or prevents you from participating in more physical activity or exercise (e.g. joint problems, arthritis, time)?	
Do you have membership at any gyms or exercise facilities? Which one(s)?	

Behavior Styles, Stress, and Sleep Hygiene	
Behavior Style (select only one of the options)	☐ You are calm and easygoing ☐ You are sometimes calm but frequently impatient ☐ You are seldom calm and have overwhelming drive for ambition ☐ You are hard driving and can never relax
Please circle your **STRESS** level:	0 1 2 3 4 5 6 7 8 9 10 0=no stress 5=moderate stress 10=extreme stress
Please describe major sources of stress in your life and how they affect you:	
Sleep Hygiene and Sleep Patterns (select all that apply)	* What time do you usually go to sleep? * What time do you usually wake up? * Do you wake up through the night? ☐ no ☐ yes * Do you wake up and eat overnight? ☐ no ☐ yes ☐ I usually sleep 8 or more hours per night ☐ I usually sleep 6 - 8 hours per night ☐ I usually sleep 4 - 6 hours per night ☐ I usually sleep < 4 hours per night ☐ I snore heavily at night ☐ I wake up in the morning still tired ☐ Have you ever had a sleep study? ☐ no ☐ yes ☐ I have sleep apnea; if yes do you use CPAP? ☐ no ☐ yes ☐ I work and live a night schedule and sleep during the day



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Please list Current Medications and Dosages:

Do you have any of the following:

☐ Kidney Stones	☐ Glaucoma	☐ Sulfa Allergy
☐ Seizures	☐ Bulimia	☐ Cardiac Disease
☐ Medullary Thyroid Cancer	☐ Multiple Endocrine Neoplasia TYPE II	☐ Renal Failure or Kidney Disease
☐ Liver Disease	☐ Uncontrolled Hypertension	☐ Opioid/Narcotic Medical Use
☐	☐	☐

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient: ______________________________

Date reviewed by physician with patient: ______________________________

Physician Signature: ______________________________