BaylorScott&White
DIGESTIVE DISEASES GROUP
CARROLLTON
A member of HealthTexas Provider Network

Dear Patient,

I am excited to be on this medical weight management journey with you! Your evaluation starts with the **weight management packet**. You will find the following included:

- Comprehensive questionnaire
- Food diary
- Sleep Apnea questionnaire
- Sleepiness Scale questionnaire
- Eating patterns questionnaire
- Eating habits questionnaire
- Mood questionnaire

These are to be returned (fax or mailed) so they may be reviewed prior to your actual visit. Please complete at least one day of the food diary. Your medical evaluation includes an interview, discussion of the questionnaire, physical exam, body composition analysis and when applicable, metabolic rate testing. The treatment plan will include behavior, nutrition and physical activity recommendations. Referrals to other health care providers may be made to facilitate behavior, nutrition and physical activity goals. When necessary and desired, medication will be used to help achieve desired weight loss.

I look forward to seeing you at your first weight management visit!

Terilyn Scott-Winful, MD
Board Certified in Gastroenterology and Obesity Medicine

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Medical Weight Management Health Questionnaire

This form is for you to answer and return before your appointment

Name: _____ Date: _____

1. Why do you want to lose weight?

_____

_____

2. Who referred you or who is your PCP? _____

3. Have you ever tried to lose weight before? _____

If so, what worked? _____

_____

What did not work? _____

5. Have you ever had a:

	Date (s)	Findings
Upper GI endoscopy		
Colonoscopy		
Upper GI series		
CT scan		
MRI		
Ultrasound		
Weight loss surgery		

7. Have you had any labs recently? _____ If so, where? _____

8. Please list any hospital visits:

_____

_____

_____

_____

9. Please list your medications (even the ones you should be taking but are not.☺):

_____

_____

_____

_____

10. Please list any medication or food allergies:

_____

11: Do you smoke: YES NO, never have NO, used to (CIRCLE ONE)

12: Do consume alcoholic beverages? YES NO, never have NO, used to (CIRCLE ONE)

If so, how much_____ How often? _____

13: Please list any family history and in whom these illnesses occurred.

COLON CANCER _____

LIVER DISEASE _____

CROHN'S DISEASE _____

ULCERATIVE COLITIS _____

CELIAC DISEASE _____

PANCREATITIS _____

GASTRIC CANCER _____

PANCREATIC CANCER _____

ESOPHAGEAL CANCER _____

OTHER ILLNESSES _____

_____

_____

14: Are you interested in medications to help you lose weight?

Not interested Very Interested

1 2 3 4 5 6 7 8 9 10

15: Are you interested in replacing most or all meals with supplements or shakes and bars to lose weight?

Not interested Very Interested

1 2 3 4 5 6 7 8 9 10

16: Are you interested in surgery to help you lose weight?

Not interested Very Interested

1 2 3 4 5 6 7 8 9 10

17: Do you have physical conditions that prevent you from exercising? Yes No (CIRCLE ONE)

If yes, what prevents you from exercising? _____

_____

18: How much exercise do you get weekly (Note: this is expressed episodes of physical activity for improving your health not the physical activity involved with work or your activities of daily living).

Days per week:	1	2	3	4	5	6	7
Minutes per day:	15	30	45	60	>60		

19: How much resistance training do you do weekly?

Days per week:	1	2	3	4	5	6	7
Minutes per day:	15	30	45	60	>60		

20: How confident are you that you will be able to lose weight?

Not confident Very confident

1 2 3 4 5 6 7 8 9 10

Thank you for completing this form. This will help us take better care of you!

Name: _____ Today's Date: _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, weakness, insomnia, chills
Other:_____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Reviewed by provider: _____

FOOD DIARY FOR: _____ DATE: ____/____/____ SUN MON TUES WED THURS FRI SAT
(circle one)

TIME	AMOUNT	FOOD SELECTION	HUNGER LEVEL	MOOD	GI SYMPTOMS

Activity (10 minutes per circle) ○○○○○○○○○

Water (8 oz per circle) ○○○○○○○○

Fiber (5 grams per circle) ○○○○○

Sleep (1 hour per circle – minimum 7) ○○○○○○○○○

Multivitamin ○

Calcium ○○

Supplements ○○○

BMI _____

Waist Circumference _____

Photocopy these 2 pages for everyday use of this food diary. Food diaries often provide an area to document mood and level of hunger to help get a handle on the emotional attachment that drives our bad eating habits which can lead to obesity.

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No
BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No
TOTAL SCORE		

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total: _____

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

This survey asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as:

- **Sweets like ice cream, chocolate, doughnuts, cookies, cake, candy, ice cream**
- **Starches like white bread, rolls, pasta, and rice**
- **Salty snacks like chips, pretzels, and crackers**
- **Fatty foods like steak, bacon, hamburgers, cheeseburgers, pizza, and French fries**
- **Sugary drinks like soda pop**

When the following questions ask about "CERTAIN FOODS" please think of ANY food similar to those listed in the food group or ANY OTHER foods you have had a problem with in the past year

IN THE PAST 12 MONTHS:	Never	Once a month	2-4 times a month	2-3 times a week	4 or more times or daily
1. I find that when I start eating certain foods, I end up eating much more than planned	0	1	2	3	4
2. I find myself continuing to consume certain foods even though I am no longer hungry	0	1	2	3	4
3. I eat to the point where I feel physically ill	0	1	2	3	4
4. Not eating certain types of food or cutting down on certain types of food is something I worry about	0	1	2	3	4
5. I spend a lot of time feeling sluggish or fatigued from overeating	0	1	2	3	4
6. I find myself constantly eating certain foods throughout the day	0	1	2	3	4
7. I find that when certain foods are not available, I will go out of my way to obtain them. For example, I will drive to the store to purchase certain foods even though I have other options available to me at home.	0	1	2	3	4
8. There have been times when I consumed certain foods so often or in such large quantities that I started to eat food instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
9. There have been times when I consumed certain foods so often or in such large quantities that I spent time dealing with negative feelings from overeating instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.	0	1	2	3	4
10. There have been times when I avoided professional or social situations where certain foods were available, because I was afraid I would overeat.	0	1	2	3	4
11. There have been times when I avoided professional or social situations because I was not able to consume certain foods there.	0	1	2	3	4
12. I have had withdrawal symptoms such as agitation, anxiety, or other physical symptoms when I cut down or stopped eating certain foods. (Please do NOT include withdrawal symptoms caused by cutting down on caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
13. I have consumed certain foods to prevent feelings of anxiety, agitation, or other physical symptoms that were developing. (Please do NOT include consumption of caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)	0	1	2	3	4
14. I have found that I have elevated desire for or urges to consume certain foods when I cut down or stop eating them.	0	1	2	3	4
15. My behavior with respect to food and eating causes significant distress.	0	1	2	3	4
16. I experience significant problems in my ability to function effectively (daily routine, job/school, social activities, family activities, health difficulties) because of food and eating.	0	1	2	3	4

IN THE PAST 12 MONTHS:	NO	YES
17. My food consumption has caused significant psychological problems such as depression, anxiety, self-loathing, or guilt.	0	1
18. My food consumption has caused significant physical problems or made a physical problem worse.	0	1
19. I kept consuming the same types of food or the same amount of food even though I was having emotional and/or physical problems.	0	1
20. Over time, I have found that I need to eat more and more to get the feeling I want, such as reduced negative emotions or increased pleasure.	0	1
21. I have found that eating the same amount of food does not reduce my negative emotions or increase pleasurable feelings the way it used to.	0	1
22. I want to cut down or stop eating certain kinds of food.	0	1
23. I have tried to cut down or stop eating certain kinds of food.	0	1
24. I have been successful at cutting down or not eating these kinds of food	0	1

25. How many times in the past year did you try to cut down or stop eating certain foods altogether?	1 time	2 times	3 times	4 times	5 or more times

26. Please circle ALL of the following foods you have problems with:

Ice cream	Chocolate	Apples	Doughnuts	Broccoli	Cookies	Cake	Candy
White Bread	Rolls	Lettuce	Pasta	Strawberries	Rice	Crackers	Chips
Pretzels	French Fries	Carrots	Steak	Bananas	Bacon	Hamburgers	Cheese burgers
Pizza	Soda Pop	None of the above					

27. Please list any other foods that you have problems with that were not previously listed:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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