Medical Weight Management Program
Pre - Program Questionnaire

As part of our medical clearance, we need information about your health. All information is confidential.

Name	Medical Record Number:
Date	Date of Birth
Address 1	Best Contact Phone Number
Email	Referring Provider

1. Please list your current medications (prescription and non-prescription). Please use reverse if necessary.

Name	Reason for taking	Name	Reason for taking

2. Do you have any of the following (circle if yes)?

- High Blood Pressure (on medication)
- Diabetes (on medication)
- Actively treated for Depression or Anxiety
- Smoker
- History of abuse i.e sexual, child, domestic
- Cannot be in classes alone (need escort at all times)
- Bipolar disorder (on medication)
- History of Depression or Anxiety
- Binge eating, purging your food, or a history of being severely underweight at any point
- Substance addiction (drugs, pain meds or alcohol) Please specify: Drinks/day:___Drinks/wk: ____ Other_____

3. What is your current weight and height? _____lbs _____ft _____inches

4. How much weight do you hope to lose in this 82wk program? _____Lbs

5. Approximately how many times have you lost > 20#'s? How did you achieve this? Why are you choosing this program now?

6. Are you able to participant in weekly group sessions where you will discuss your eating and exercise habits with others in your group?

7. Are you able to participate in weekly group sessions where you will discuss your eating and exercise habits with others in your group? ☐ Yes ☐ No

8. Is there anything about being in a group that worries you? ☐ Yes ☐ No

   If yes, please describe briefly: _____

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Name: **Medical Record Number:**

For your safety, we require communication with your Primary Care Physician. Therefore we need your PCP and insurance information. If your PCP information changes please let us know.

Name of Primary Care Physician: _____

Phone Number: (___)_____ Address:

Insurance Carrier: _____ Policy Number and /or MRN:_____

a. How did you hear about this program? _____

- ☐ Program brochure/flyer/poster
- ☐ Medical Weight Management website
- ☐ At an appointment with a PCP or other provider
- ☐ From a friend, family member or KP employee
- ☐ Education) Advertisement or article
- ☐ From a program participant
- ☐ Physician Letter
- ☐ Email
- ☐ KP class catalog (Health
- ☐ Other (Please specify:_____)

Who may we thank for your referral (if applicable)? _____

b. If you are undecided about joining our program, may we contact you? ☐ Yes ☐ No

c. If you are undecided, what is the main reason for your indecision?

- ☐ Not ready
- ☐ Cannot afford program
- ☐ Medical_____
- ☐ Upcoming vacation
- ☐ Personal
- ☐ Other _____

d. Can we leave a detailed voicemail message with information about this program if no one answers the phone number provided above? ☐ Yes ☐ No

e. Can we e-mail you about any upcoming appointments for this program from an email system that is not secure (i.e. not guarded by a security system to keep this contract private from other web users)? We would not send specific health data about you, but may include information about the subject of this class or a survey.
☐ Yes ☐ No

I understand that my Medical Weight Management program provider may contact my primary care physician or my other health care providers about my medical conditions or history. I authorize the providers of The Permanente Medical Group to discuss my medical conditions or history with any of my treatment providers or to request additional information. I authorize my health care providers to release this information to The Permanente Medical Group

Signature: _____