

Comprehensive Weight Management Program



Dean Clinic – West
752 N. High Point Rd.
Madison, WI 53717
(608) 824-4457

Dean Clinic – East
1821 S. Stoughton Rd.
Madison, WI 53716
(608) 824-4457

Dean Clinic – Janesville East
3200 E. Racine Street
Janesville, WI 53546
(608) 371-8390

CONFIDENTIAL

Date _____ Information session attended on _____ Webinar viewed on _____

I understand my insurance coverage and my financial responsibility **yes** **no**

(**Staff use only:** Appt. Scheduled _____)

PERSONAL INFORMATION

Last name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (home) (____) _____ (cell) (____) _____

May we call you at home? **yes** **no** May we call your cell? **yes** **no**

Telephone (work) (____) _____ May we call you at work? **yes** **no**

Email address _____ Birthdate _____ Age _____ Sex _____

Emergency contact person (name): _____ Relationship: _____

Emergency telephone: (____) _____ Secondary telephone: (____) _____

Primary care physician: (____) _____

Clinic Address: _____

Clinic Telephone: (____) _____

Date of your last physical exam? _____

List other physicians you see: _____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber Name: _____ Member Subscriber # _____

Group # _____

Do you have insurance coverage for obesity care? **yes** **no**

Are you interested in weight loss surgery? **yes** **no**

How do you rate your health? _____ Poor _____ Fair _____ Good

WEIGHT HISTORY

Current weight _____ Height _____

How old were you when your weight became a problem? _____

What is your lowest adult weight? _____ What is your highest adult weight? _____

What is your goal weight? _____

Have you had weight loss surgery? **yes** **no**

If yes, When? _____ Where? _____

What makes it difficult for you to lose weight and keep it off? _____

Have you taken prescription medication for weight loss? **yes** **no** _____

Did you use Fen/Phen in the 1990's? **yes** **no**, _____ months

List the weight loss diets you have used.

PROGRAM	When?	How long?	Pounds lost?	Pounds Regained?	Reason stopped?
Atkins					
Weight Watchers					
Slim-Fast					
Jenny Craig					
LA Weight Loss					
Nutri-System					
Liquid Diet					
Overeaters Anonymous					

NUTRITION

List one or two things you would like to change about your eating habits.

In a typical **WEEK**:

How many meals do you eat with your family? _____

How many restaurant meals do you eat? _____

How many fast food meals do you eat? _____

How many alcoholic drinks do you have? _____

Circle the activities that trigger you to eat even if you are not hungry?

meeting with friends	watching TV	reading	attending meetings	studying	computer work	work
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Circle the emotions that trigger you to eat even if you are not hungry?

boredom	fatigue	anger	sadness	loneliness	anxiety	worry	happiness	fear
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In the following chart, describe what, when, and where you eat in a typical day.

Meal	Time	Where	Foods eaten and amount
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

PHYSICAL ACTIVITY

What is the most physically active thing you do in a day? _____

Is there any reason you should not exercise? _____

Do you need a cane, walker or wheelchair to get around? **yes** **no**

List any regular exercise you do. _____

CHANGE

How ready do you feel to change your lifestyle?

not at all 1 2 3 4 5 6 7 8 9 10 very ready

How confident are you that you will be able to change your lifestyle?

not at all 1 2 3 4 5 6 7 8 9 10 very confident

MEDICAL HISTORY

Common Obesity Related Diseases	YES	NO
Type II Diabetes (<i>year diagnosed</i> _____)		
High blood pressure		
High cholesterol		
High triglycerides		
Sleep apnea		
Using CPAP		
GERD/Reflux/Heartburn		
Arthritis		
Fatty liver disease		
Gall stones		
Gout		

Heart Problems	YES	NO
Heart attack		
Irregular heartbeat		
Chest pain		
Chest pain with exertion		
Congestive heart failure		

Respiratory Problems	YES	NO
Asthma		
COPD/Emphysema		
Shortness of breath		

Gastrointestinal Problems	YES	NO
Hiatal hernia		
Stomach ulcer		
Diarrhea		
Constipation		
Celiac disease		

Genitourinary Problems	YES	NO
Leaking urine		
Frequent bladder infections		
Kidney stones		
Heavy menstrual bleeding		
Enlarged prostate		
Are you planning a pregnancy? (women)		

Musculoskeletal Problems	YES	NO
Back pain		
Hip pain		
Knee pain		
Foot pain		

Endocrine Problems	YES	NO
Thyroid disease		
Polycystic Ovarian Syndrome		
Gestational Diabetes		

Skin/Hair Problems	YES	NO
Rash in skin folds		
Eczema		
Excess facial hair (women)		

Blood Problems	YES	NO
Anemia		
Blood clots in legs or lungs		

Neurologic Problems	YES	NO
Seizure disorder		
Migraine headache		
Multiple Sclerosis		
Stroke		

Cancer	YES	NO
Cancer		
Type		

Mental Health Problems	YES	NO
Depression		
Anxiety		
Bipolar Disorder		
ADHD		
Obsessive Compulsive Disorder		
Binge Eating Disorder		
Anorexia Nervosa		
Bulimia		
Sexual abuse		
Alcohol or drug addiction		
Schizophrenia		

List other medical conditions you have.

SURGICAL HISTORY

Have you or a family member had problems with general anesthesia? **yes** **no**

List the surgeries you have had. When? Where?

FAMILY HISTORY

	Obesity	Diabetes	Heart Disease	Cancer
Mother				
Father				
Brother				
Brother				
Sister				
Sister				
Daughter				
Son				
Spouse/partner				

SOCIAL HISTORY

Are you? Married Single Divorced In a Long Term Relationship

How many children do you have? _____

What is your job title? _____

Where do you work? _____

What are your work hours? _____

What is your highest level of education? _____

How many hours do you sleep in a typical night? _____

	YES	NO
Do you smoke?		
Do you drink alcohol?		
Do you use recreational drugs? (marijuana, cocaine, other)		
Have you ever been treated for alcohol or drug abuse?		
In the last month, were there any days when you did not have enough money to buy food?		

List the people in your household and their relationship to you. _____

Who do you count on for emotional support? _____

How do you cope with stress in your daily life? _____

MEDICATIONS

List all of your prescription medication.

Medication Name	Dose	How many times per day?	Why do you take it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all vitamins, minerals, supplements, and herbs you take.

Name	Dose	How many times per day?	Why do you take it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Do you have food allergies? **yes** **no**

Please list _____

Are you allergic to Latex? **yes** **no**

Are you allergic to any medications? **yes** **no**

Please list _____

Thank you for taking the time to complete this questionnaire. We will review this information and call you within 1 - 2 weeks to schedule a consultation appointment. Before your appointment please call your insurance company to review your weight management coverage. Insurance coverage varies by employer. Not all Dean Policies provide the same coverage. It is beneficial to you to understand your coverage and financial responsibilities before your appointment.

Please return your questionnaire by mail, fax, or email:

Dean Clinic – West
CWMP LL/Questionnaire
752 N. High Point Road
Madison, WI 53717
Fax: (608) 824-4859
Email: weightmanagement@deancare.com

Information and Appointments: (608) 824-4457 | Toll Free: (800) 808-1190 | Fax: (608) 824-4859
Email: weightmanagement@deancare.com | Website: deancare.com/weightmanagement