SLIM LIFE SOLUTIONS
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PERSONAL HEALTH & NUTRITION / DIET HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Marital Status: Single Married Divorced Separated Widowed Other

I am currently living with: (Write in the # of each)
- ❑ Alone
- ❑ Spouse
- ❑ Significant Other
- ❑ Children #_____
- ❑ Siblings #_____
- ❑ Parents/Step parents #_____
- ❑ Other _____

Total in household: _____

Highest year of education completed: _____

Occupation: _____

If retired, previous occupation _____

Any life stressors? Y N If yes, please describe:

_____

_____

FAMILY WEIGHT HISTORY

Please indicate the average height and weight of your biological / immediate family during their middle age years.

	Height (ft and in)	Weight (lbs)	Current age or Age at death		Major health problems and / or Cause of death
Mother	_____	_____	_____	❑ Alive ❑ Deceased	
Father	_____	_____	_____	❑ Alive ❑ Deceased	
Sibling (M / F)	_____	_____	_____	❑ Alive ❑ Deceased	
Sibling (M / F)	_____	_____	_____	❑ Alive ❑ Deceased	
Sibling (M / F)	_____	_____	_____	❑ Alive ❑ Deceased	
Sibling (M / F)	_____	_____	_____	❑ Alive ❑ Deceased	
Sibling (M / F)	_____	_____	_____	❑ Alive ❑ Deceased	
Spouse / Partner	_____	_____	_____	❑ Alive ❑ Deceased	

WEIGHT LOSS GOALS

How much weight would you like to lose? _____ lbs What is your goal weight? _____ lbs

How did you come up with that number? _____

WEIGHT HISTORY

Current Height: _____ Current Weight: _____ Is your frame (bone-size): Large Medium Small

What is the size of your: Waist _____ inches Hips _____ inches

What has been your…
Maximum adult weight? _____ Age: _____ Minimum adult weight? _____ Age: _____

At what age were you first overweight by 10 lbs or more? _____

How many years have you been overweight? _____ How many times have you lost your excess weight? _____

For each time period shown below, please list your minimum and maximum weights.
Also note events related to weight gain during each period (i.e. child birth, college, etc).
If you cannot remember what your weights were, estimate and mark (E)

	Min Weight	Max Weight	Events Leading To Weight Gain	Max BMI *Staff Use*
Birth weight	_____			
Age 5-10	_____	_____	_____	
Age 10-15	_____	_____	_____	
Age 15-20	_____	_____	_____	
Age 20-25	_____	_____	_____	
Age 25-30	_____	_____	_____	
Age 30-35	_____	_____	_____	
Age 35-40	_____	_____	_____	
Age 40-45	_____	_____	_____	
Age 45-50	_____	_____	_____	
Age 50-55	_____	_____	_____	
Age 55-60	_____	_____	_____	
Beyond 60	_____	_____	_____	

DIETING HISTORY

Approximate age when you first seriously started to diet: _____

Please record any major diets, which have resulted in a weight loss of 10 lbs. or more. Take time to think over your previous diets, starting with the first one, whether during childhood or adulthood, and proceed to most recent.

	Dates	Duration	MD Supervised	Max Wt Loss	Wt Regained
Diet Center			❑ Yes ❑ No		
Jenny Craig			❑ Yes ❑ No		
Lindora			❑ Yes ❑ No		
Nutri-Systems			❑ Yes ❑ No		
O.A.			❑ Yes ❑ No		
T.O.P.S.			❑ Yes ❑ No		
Weight Watchers			❑ Yes ❑ No		
Cambridge			❑ Yes ❑ No		
Hollywood Diet			❑ Yes ❑ No		
Medi-Fast			❑ Yes ❑ No		
OptiFast			❑ Yes ❑ No		
Atkins Diet			❑ Yes ❑ No		
Cabbage Soup Diet			❑ Yes ❑ No		
Dr Phil			❑ Yes ❑ No		
Grapefruit Diet			❑ Yes ❑ No		
Pritiken Diet			❑ Yes ❑ No		
Protein Powders			❑ Yes ❑ No		
Scarsdale			❑ Yes ❑ No		
South Beach Diet			❑ Yes ❑ No		
Sugar Busters			❑ Yes ❑ No		
The Zone			❑ Yes ❑ No		
Fasting / Restriction			❑ Yes ❑ No		
Low calorie			❑ Yes ❑ No		
Low fat			❑ Yes ❑ No		
Dexatrim			❑ Yes ❑ No		
Fen/Phen			❑ Yes ❑ No		
Herbalife			❑ Yes ❑ No		
Meridia			❑ Yes ❑ No		
Metabolife			❑ Yes ❑ No		
Phentermine			❑ Yes ❑ No		
Redux			❑ Yes ❑ No		
Xenadrine			❑ Yes ❑ No		
Acupuncture			❑ Yes ❑ No		
Hypnotist			❑ Yes ❑ No		
Nutritionist / Dietitian			❑ Yes ❑ No		
Exercise			❑ Yes ❑ No		
Diet and Exercise			❑ Yes ❑ No		
Other			❑ Yes ❑ No		
Other			❑ Yes ❑ No		

Estimate how clear your memory is on this form 1-10. 1=vague, 10=completely accurate _____

DIETING HISTORY, continued…

Have you ever engaged in bulimic behaviors (vomiting or using laxatives) to lose weight? _____

Have you ever been diagnosed with anorexia nervosa, or felt you were out of control around food? _____

Do you feel you may have problems with binge eating, or have you in the past? _____

WEIGHT, PREGNANCY, and MENSTRUAL CYCLE

Do you currently experience menstrual cycles? Regular Irregular No

Please circle below which best describes your eating habits around the time you are menstruating. (CIRCLE ONE)

Eat much less Eat less No Change Eat More Eat Much More

Do or did you crave particular food(s) during menstruation: Yes No

If yes, what food(s) were they?

Please answer the following if you are currently of childbearing years:

Are you sexually active:
- ❑ Yes
- ❑ No

Are you currently using any type of birth control?
- ❑ Yes What type? _____
- ❑ No

TOBACCO, ALCOHOL and SUBSTANCE USE

Do you currently smoke cigarettes or cigars? ❑ Yes ❑ No If yes, how many per day? _____

Have you ever smoked cigarettes or cigars? ❑ Yes ❑ No For how many years? _____

Have you ever tried to stop smoking? ❑ Yes ❑ No Was this successful? ❑ Yes ❑ No

When did you stop smoking? _____ What method did you use? _____
(Nicotine patch, gum, "cold turkey", etc)

Did you experience any weight gain after you stopped smoking? ❑ Yes ❑ No

If yes, how many pounds did you gain? _____

Do you drink alcoholic beverages? ❑ Yes ❑ No

If yes, how many beverages do you drink per week? _____

Preferred type of beverage (CIRCLE AS MANY AS APPLY) Wine Beer Mixed Drink Shot

Have you ever had a problem with excessive alcohol or other drug consumption? ❑ Yes ❑ No

If yes, please describe the problem and the help you received for it if any.

Food Frequency

Fill out according to your current dietary behaviors.

Instructions:
1. Circle types of foods listed in parentheses where appropriate.
2. Write in how many times you consume these foods.
3. Circle day/week/or month after each.

Food:	(circle kinds)	(# of servings)	circle	Additional comments:

DAIRY:

Milk	(skim, 1%, 2%, Whole)	_____	day/week/month
Cottage Cheese	(regular/Lite)	_____	day/week/month
Yogurt	(regular/Lite)	_____	day/week/month
Cheese	(regular/Lite)	_____	day/week/month

FRUITS:

Fresh, frozen, canned	_____	day/week/month
Fruit Juices, 6 oz.	_____	day/week/month

VEGETABLES:

(Not including corn, peas, potatoes)

Fresh, frozen, canned	_____	day/week/month

MEATS:

Beef	(steak, roast)	_____	day/week/month
Hamburger	(_____% lean)	_____	day/week/month
Chicken	(white, dark)	_____	day/week/month
Deli Meats		_____	day/week/month
Pork	(chops, roast)	_____	day/week/month
Tuna	(in oil, in water)	_____	day/week/month
Seafood		_____	day/week/month
Eggs		_____	day/week/month
Peanut Butter		_____	day/week/month
Dry Beans		_____	day/week/month

CARBOHYDRATES:

Bread	(white, wheat)	_____	day/week/month
Bagels		_____	day/week/month
Rice		_____	day/week/month
Pasta		_____	day/week/month
Potatoes		_____	day/week/month
Corn & peas		_____	day/week/month
Crackers		_____	day/week/month

SWEETS/SNACKS/FATS:

Cakes	_____	day/week/month
Cookies	_____	day/week/month
Donuts	_____	day/week/month
Ice cream	_____	day/week/month
Chocolate	_____	day/week/month
Candy	_____	day/week/month
Regular Soda	_____	day/week/month
Chips	_____	day/week/month
Pretzels	_____	day/week/month
Sour cream / Cream cheese	_____	day/week/month
Butter / Margarine	_____	day/week/month
Mayo / Salad Dressing	_____	day/week/month

ALCOHOL: _____ day/week/month

FAST FOOD: _____ day/week/month

EATING PATTERNS AND FOOD PREPARATION

How many <u>days a week</u> do you eat the following:

	# of Days	Time of Day	Where		# of Days	Time of Day	Where
Breakfast	_____	_____	_____	Afternoon Snack	_____	_____	_____
Morning Snack	_____	_____	_____	Dinner	_____	_____	_____
Lunch	_____	_____	_____	Evening Snack	_____	_____	_____

Who prepares meals at home? _____ Who shops for the food? _____

Do you get up at night to eat? ❑ Yes ❑ No If yes, how many times per night? _____

Please list five of your favorite foods/beverages:

1. _____
2. _____
3. _____
4. _____
5. _____

How often do you dine out?

_____

What do you put in your tea or coffee? _____

Please list the amount (in cups) you drink of the following on an average day:

___ Water ___ Seltzer water ___ Whole milk ___ Low-fat milk
___ Skim milk ___ Fruit juice ___ Diet soda ___ Non-diet soda
___ Kool-aid ___ diet Kool-aid ___ iced tea mix ___ diet iced tea mix
___ tea ___ decaf tea ___ coffee ___ decaf coffee
___ beer ___ hard liquor ___ wine ___ Gatorade-type
___ other (specify)

What restaurants do you frequently visit? _____

<u>EATING HABITS</u>

Please indicate the degree of which each of the following behaviors causes you to gain weight. Use the 5-point scale listed below to best describe how much of the behavior contributes to your increased weight.

1. Does not contribute at all
2. Contributes a small amount
3. Contributes a moderate amount
4. Contributes a moderate amount
5. Contributes the greatest amount

_____ eating too much food
_____ overeating at breakfast
_____ overeating at lunch
_____ overeating at dinner
_____ snacking between meals
_____ snacking after dinner
_____ eating because I feel physically hungry
_____ eating because I don't feel full
_____ eating because I can't stop once I've begun
_____ eating because of the good taste of food
_____ eating in response to sight or smell of food
_____ eating because I crave certain foods.
What type of food(s)? _____

_____ eating while cooking or preparing food
_____ eating when anxious
_____ eating when tired
_____ eating when bored
_____ eating when stressed
_____ eating when angry
_____ eating when depressed/upset
_____ eating when socializing /celebrating
_____ eating when happy
_____ eating when alone
_____ eating with family and/or friends
_____ eating at business functions
_____ eating and not being aware of it
_____ eating when pressured from others

Please note any other factors, which contribute a moderate or large amount of your weight gain.

EATING PATTERNS

During the past 6 months have you often eaten a large amount of food within a 2-hour period? (an amount most people would agree is unusually large)
- ❑ Yes
- ❑ No

During times when you have eaten an unusually large amount of food, did you feel like you couldn't control how much you were eating?
- ❑ Yes
- ❑ No

If NO to these questions, skip to PHYSICAL ACTIVITY:

A. During past 6 months…

How often, on average, did you have times when you ate unusually large amounts of food and felt that your eating was out of control?

- ❑ less than one day a week.
- ❑ one day a week
- ❑ two or three days a week
- ❑ four or five days a week
- ❑ nearly every day

How upset were you by overeating episodes in which you ate unusually large amounts of food?

- ❑ Not at all
- ❑ Slightly
- ❑ Moderately
- ❑ Greatly
- ❑ Extremely

B. Did you usually have many of the following experiences during these occasions?

Eating much more rapidly than usual?	Yes	No
Eating until you felt uncomfortable?	Yes	No
Eating large amounts of food when physically not hungry?	Yes	No
Feeling disgusted with yourself, depressed, guilty after overeating?	Yes	No
Eating large amounts of food throughout the day with no planned mealtime?	Yes	No

C. Think about a typical time when you ate this way (large amounts of food, feeling that your eating was out of control)

What time of day did the episode start?

- ❑ Morning (8am-noon)
- ❑ Early afternoon (Noon to 4:00pm)
- ❑ Late afternoon (4:00pm-7: 00pm)
- ❑ Evening (7:00pm-10: 00pm)
- ❑ Night (after 10:00pm)

Approximately how long did this episode last, from the time you started to eat, until you stopped and did not eat again for at least 2 hours?

_____ Hours _____ Minutes

At time of episode, how long had it been since you had previously finished eating a meal or snack?

_____ Hours _____ Minutes

As best as you can remember, please list everything you might have eaten or drunk during that last episode. If you ate for more than 2 hours, describe the food eaten and liquids drunk that you ate the most. Be specific; include amounts and brand names (when possible). Estimate as best you can.

Food	Amount	Brand (If possible)

PHYSICAL ACTIVITY

To what extent do you enjoy physical activity?
- ❑ Not at all
- ❑ Slightly
- ❑ Moderately
- ❑ Greatly

Other than your obesity, do you have any physical problems that limit your physical activity?
- ❑ No
- ❑ Yes… if yes, describe: _____

What type of physical activity or activities do you enjoy the most?

How many times have you participated in this activity during the last 6 months? _____ times

How many hours of TV do you generally watch during the week (M-F) _____ hours

How many hours of TV do you generally watch on the weekend (S/S) _____ hours

Describe any other types of activity that you enjoy doing (i.e. computers, reading etc):

On average, how many hours do you spend on that activity…

Each weekday? _____ hours

Each weekend day? _____ hours

Approximately how many city blocks or equivalent do you regularly walk each day? *(12 blocks = 1 mile)*

_____

Approximately how many flights of stairs do you climb up each day? *(10 steps = 1 flight)*

_____ flights

Are you a member of a gym, a sports team, or any other formal exercise program? ❑ Yes ❑ No
If yes, what?

When you are exercising in your current usual fashion, how would you rate your level of exertion (degree of effort)

Rate on a scale of 1-10, 1=nothing, 10=maximal _____

List any sports or recreations you have actively participated in that you have enjoyed in the past.

Sport / Recreation Activity	Average Times / Month	Are you able to do this activity now?		If no, why not?
		❑ Yes	❑ No	
		❑ Yes	❑ No	
		❑ Yes	❑ No	
		❑ Yes	❑ No	

CURRENT AND PAST PHYSICIAN(S)

*Please fill out for any doctors you have seen in the **past 5 years**:*

1. PHYSICIAN NAME: _____
   ADDRESS: _____
   _____
   PHONE NUMBER: _____
   FAX NUMBER: _____
   DATES OF TREATMENT: _____
   Is it okay for us to contact this physician for records? ❑ Yes ❑ No

   What specialty is this doctor?
   ❑ Primary Care Doctor
   ❑ Gastroenterologist (GI)
   ❑ Cardiologist
   ❑ Ob-Gyn
   ❑ Internal Medicine
   ❑ Endocrinologist
   ❑ Other: _____

2. PHYSICIAN NAME: _____
   ADDRESS: _____
   _____
   PHONE NUMBER: _____
   FAX NUMBER: _____
   DATES OF TREATMENT: _____
   Is it okay for us to contact this physician for records? ❑ Yes ❑ No

   What specialty is this doctor?
   ❑ Primary Care Doctor
   ❑ Gastroenterologist (GI)
   ❑ Cardiologist
   ❑ Ob-Gyn
   ❑ Internal Medicine
   ❑ Endocrinologist
   ❑ Other: _____

3. PHYSICIAN NAME: _____
   ADDRESS: _____
   _____
   PHONE NUMBER: _____
   FAX NUMBER: _____
   DATES OF TREATMENT: _____
   Is it okay for us to contact this physician for records? ❑ Yes ❑ No

   What specialty is this doctor?
   ❑ Primary Care Doctor
   ❑ Gastroenterologist (GI)
   ❑ Cardiologist
   ❑ Ob-Gyn
   ❑ Internal Medicine
   ❑ Endocrinologist
   ❑ Other: _____

4. PHYSICIAN NAME: _____
   ADDRESS: _____
   _____
   PHONE NUMBER: _____
   FAX NUMBER: _____
   DATES OF TREATMENT: _____
   Is it okay for us to contact this physician for records? ❑ Yes ❑ No

   What specialty is this doctor?
   ❑ Primary Care Doctor
   ❑ Gastroenterologist (GI)
   ❑ Cardiologist
   ❑ Ob-Gyn
   ❑ Internal Medicine
   ❑ Endocrinologist
   ❑ Other: _____

5. PHYSICIAN NAME: _____
   ADDRESS: _____
   _____
   PHONE NUMBER: _____
   FAX NUMBER: _____
   DATES OF TREATMENT: _____
   Is it okay for us to contact this physician for records? ❑ Yes ❑ No

   What specialty is this doctor?
   ❑ Primary Care Doctor
   ❑ Gastroenterologist (GI)
   ❑ Cardiologist
   ❑ Ob-Gyn
   ❑ Internal Medicine
   ❑ Endocrinologist
   ❑ Other: _____

Have you ever previously undergone any form of weight loss surgery? ❑ **Yes** ❑ **No**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **D.O.B.** _____

I hereby authorize:

Afshin Eslami, M.D.
7501 Hospital Drive, Suite 305
Sacramento, CA 95823
Phone: 916-423-2022 Fax: 916-681-0673

❑ to obtain the medical records listed below from **any** medical provider / facility, or

❑ to obtain from the following:

_____
Name of Doctor / Facility

_____
Address, Suite

_____
City, State, Zip

_____
Phone / Fax Number

❑ to release to:

Afshin Eslami, MD
Name of Doctor / Facility

7501 Hospital Drive, Suite 305
Address, Suite

Sacramento, California 95823
City, State, Zip

916-423-2022 / 916-681-0673
Phone / Fax Number

I authorize my Protected Health Information (PHI) to be used and disclosed for:

❑ Medical Care and/or Insurance ❑ Attorney ❑ Other: _____

Unless specified below, this authorization covers any and all medical records.

❑ Only release the following records:

_____

Please initial if we may obtain any of the following:

Mental Health Records: _____ *(Initial)*

Drug/Alcohol Abuse: _____ *(Initial)*

HIV Test Results: _____ *(Initial)*

Specify the dates or time period for the information selected above: _____

I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to inspect or copy my PHI to be used or disclosed as permitted under federal and/or state law. I understand I am entitled to receive a copy of this authorization upon request. I understand that information used or disclosed according to this agreement may be subject to redisclosure by the person or entity receiving my PHI, and that it then may no longer be protected by federal or state privacy regulations. I may revoke this authorization at any time by submitting a request in writing to Dr Afshin Eslami. I understand that a revocation is not retroactive or effective for past instances that Dr Afshin Eslami has relied on the previous use or disclosure of my PHI. Unless revoked, this authorization is valid for one year (12 months) from the date of consent, or until the following date/event: _____

Signed by Patient: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient: _____