KAISER PERMANENTE®

Name
Date
Medical Record #

Medical Weight Management Program
Pre-Program Questionnaire

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

Name Home/ Cell Phone Email Address

BACKGROUND

Sex: ☐ Female ☐ Male Height (w/o shoes) Weight:

Occupation: DOB: Age:

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:

Insurance Carrier: Policy Number and/or MRN:

Do you have KP.ORG on your phone or computer? ☐ Yes ☐ No

Do you own a scale at home? ☐ Yes ☐ No

Do you have a blood pressure cuff at home? ☐ Yes ☐ No

Are you comfortable with WebEx Platform? ☐ Yes ☐ No

What is the largest amount of weight you've ever lost? Lbs.

What is the most you have ever weighed?

Have you ever had any significant physical symptoms or emotional reactions while attempting to lose weight or after losing weight? ☐ Yes ☐ No

If yes, please describe your symptoms or reactions, when they occurred, and the type of professional help you sought, if any.

Have you ever been treated by a psychiatrist and/or psychologist?
☐ Yes ☐ No Dates of Treatment:

Have you ever been or are you currently being treated for an eating disorder?

☐ Yes ☐ No Dates of Treatment:

Why did you choose this program?

PERSONAL HEALTH

Please list your health problems/health diagnoses.

CURRENT MEDICATIONS

Please list your current medications (prescription and non-prescription)

Name	Strength	How Often	Reason for Taking

USE OF OTHER SUBSTANCES

Do you smoke cigarettes? ☐ Yes ☐ No
If yes, how many cigarettes per day?

How much alcohol (e.g., wine, beer, mixed drinks) do you drink in a day?

Are you presently using street drugs? ☐ Yes ☐ No

PHYSICAL ACTIVITY

Is there any physical activity you engage in regularly? ☐ Yes ☐ No

Please describe it:

FAMILY HISTORY

Are you currently: (check one)?

☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ Live-in Relationship

Who lives with you in your household?

GROUP PARTICIPATION

On a scale of 1 to 10, how comfortable do you think you will feel discussing you're eating and exercise habits with people in your group? (circle one)

1 2 3 4 5 6 7 8 9 10
Very Uncomfortable Very Comfortable

Please use the space below to discuss any other information you think is important to understanding your weight problem or your successful participation in the program.

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

Signature_____