Medical Weight Management Program
Pre-Program Questionnaire

As part of our medical clearance, we need certain information about your health. We keep all information confidential.

Date

Name

Medical Record Number

Address 1

Phone Number

Address 2

e-mail

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

2. 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

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

Name	Strength	How Often	Reason for Taking

4. Please list your health problems/health diagnoses.

5. What is your current weight and height? _____ lbs _____ ft _____ inches

6. How much weight do you hope to lose in this program? _____ lbs

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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 below.

_____

_____

_____

9. 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:_____

10. 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
☐ Advertisement or article
☐ From a program participant
☐ Letter from physician
☐ Email
☐ KP class catalog (Health Education)
☐ Other (Please specify: _____)

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

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

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

☐ Not ready
☐ Cannot afford program
☐ Medical _____
☐ Upcoming vacation
☐ Personal
☐ Other _____

13. If yes, when would you like us to follow up with you? _____ weeks/months

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