

# **Allina Health Weight Management**

Thank you for choosing Allina Health Weight Management. The Weight Management Program offers comprehensive weight loss options for patients of all ages. Please review the following descriptions to assure we get you scheduled with the right program and providers.

## **Kids, Teens and Young Adults Weight Management Program - serving ages 25 and younger**

The Kids, Teens and Young Adult program is a resource to achieve a healthier weight. Individuals and families work with medical doctors, dietitians, nurse practitioners, mental health providers, physical therapists, surgeons, and other specialists. If you are interested in the program, please complete a different intake form for that program. It can be found at [AllinaHealth.org/kidswm](http://AllinaHealth.org/kidswm).

## **Medical Weight Management Program**

**Individual Program** – The individual program is a personalized, one-on-one non-surgical program. Patients meet with a weight loss physician or nurse practitioner to create a specialized treatment plan. A registered dietitian will develop a diet tailored to your specific needs. The focus is on portion control, healthy eating, and a moderately reduced calorie diet that will work for you. This plan may include medications. The individual program cost for provider and dietitian visits is covered by most insurers, with the exception of Medicare and Medicare replacement plans.

Allina Health Weight Management offers a cash pay option for dietitian visits for Medicare and Medicare replacement plan patients.

## **Optifast Meal Replacement Program**

The Optifast program is a medically supervised complete meal replacement program. Patients are seen by a nurse practitioner or physician assistant during the active weight loss phase. Lifestyle and behavior change are key to success. The Optifast program includes monthly classes and visits with our registered dietitian. The weekly classes are taught by healthcare professionals (Registered Dietitian, Exercise Physiologist, Nurse Practitioner and Physician Assistant). Classes are 45 to 60 minutes in length and are not mandatory, but are highly encouraged as those who attend group sessions for weight management lose more weight.

## **Surgical Weight Management Program**

The surgical program offers the sleeve gastrectomy, Roux-en-Y gastric bypass, and duodenal switch operations. Your decision to have weight loss surgery is personal and complex. The Surgical Weight Management team of surgeons, physician assistants, nurse practitioners, psychologists, nurses, dietitians, and support staff will provide support, assistance, and advice throughout your journey before and after weight loss surgery.

**Please remember that with any clinic visit, co-pays,  
coinsurance and deductibles may apply.**

## Allina Health Weight Management Health History Form

Please complete form using blue or black ink

All information entered on this form will be reviewed for accuracy at your first appointments.

**Kids, Teens and Young Adult Program: this is a non-surgical and surgical program serving ages 25 and younger.**

Please use separate health history form located at [allinahealth.org/kidswm](http://allinahealth.org/kidswm) or call 763-236-0940 for a copy.

- ☐ Medical Weight Loss  
☐ Surgical Weight Loss  
☐ Optifast

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### Personal Goals

What are the goals you want to achieve in this program?

- ☐ Set an example for my kids  
☐ Less shortness of breath  
☐ Improve self esteem and confidence  
☐ Improve other medical conditions  
☐ Improve mood  
☐ Improve sleep  
☐ Reduce chronic pain  
☐ Travel comfortably on a plane  
☐ Bend forward and tie my shoes  
☐ Be able to go up a flight of stairs  
☐ Cross my legs  
☐ Have more energy with kids/grandkids  
☐ Other: \_\_\_\_\_

### Weight History

What is your current height?

What is your current weight?

BMI (this will be calculated by staff)

At what age did you first start struggling with your weight?

How many years have you been obese? Years: \_\_\_\_\_



### Allina Health Weight Management Program Health History Form



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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical History****Only complete if new to Allina** ☐ I am an Allina patient

Cardiovascular	Respiratory	Infectious Diseases	Endocrine
<input type="checkbox"/> irregular heart beat	<input type="checkbox"/> asthma	<input type="checkbox"/> HIV positive	<input type="checkbox"/> diabetes type I
<input type="checkbox"/> heart block	<input type="checkbox"/> obstructive sleep apnea	Musculoskeletal	<input type="checkbox"/> diabetes type II
<input type="checkbox"/> pacemaker	<input type="checkbox"/> pulmonary hypertension	<input type="checkbox"/> arthritis	<input type="checkbox"/> pre-diabetic
<input type="checkbox"/> heart disease	<input type="checkbox"/> emphysema	<input type="checkbox"/> gout	<input type="checkbox"/> diabetic eye problems
<input type="checkbox"/> congestive heart failure	<input type="checkbox"/> COPD	<input type="checkbox"/> plantar fasciitis	<input type="checkbox"/> diabetic ulcers
<input type="checkbox"/> heart attack (MI)	<input type="checkbox"/> pulmonary embolism	<input type="checkbox"/> joint pain	<input type="checkbox"/> low thyroid (hypothyroid)
<input type="checkbox"/> high blood pressure	Liver/Stomach/Intestine	Neurological	<input type="checkbox"/> infertility
<input type="checkbox"/> carotid artery disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> seizures	<input type="checkbox"/> hypoglycemia
<input type="checkbox"/> high cholesterol	<input type="checkbox"/> hepatitis	<input type="checkbox"/> migraines	<input type="checkbox"/> metabolic syndrome
<input type="checkbox"/> heart murmur	<input type="checkbox"/> ulcer	<input type="checkbox"/> pseudo tumor cerebri	<input type="checkbox"/> pancreatitis
<input type="checkbox"/> blood clot or DVT	<input type="checkbox"/> h. pylori	<input type="checkbox"/> paralysis	Reproductive/Female
<input type="checkbox"/> bleeding or clotting disorder	<input type="checkbox"/> colitis	<input type="checkbox"/> restless legs	<input type="checkbox"/> PCOS
Kidneys / Genitourinary	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> infertility
<input type="checkbox"/> kidney problems	<input type="checkbox"/> acid reflux or heartburn	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> menstrual irregularity
<input type="checkbox"/> currently on dialysis	<input type="checkbox"/> fatty liver (NASH or NAFLD)	<input type="checkbox"/> stroke/CVA	Other
<input type="checkbox"/> kidney stones	<input type="checkbox"/> Cirrhosis	Skin	<input type="checkbox"/> awaiting organ transplant – type: _____
	<input type="checkbox"/> pancreatitis	<input type="checkbox"/> problems with healing of wounds/cuts/bruises	<input type="checkbox"/> glaucoma
	<input type="checkbox"/> trouble swallowing		<input type="checkbox"/> history of cancer – type: _____

**Have you ever been diagnosed with:**

<input type="checkbox"/> Depression	<input type="checkbox"/> Personality disorder
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Compulsive overeating
<input type="checkbox"/> Anxiety / Panic attacks	<input type="checkbox"/> Anorexia Nervosa
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Binge eating disorder
<input type="checkbox"/> Psychosis	<input type="checkbox"/> Bulimia
<input type="checkbox"/> Other / describe	

**Check all that apply:**

	Yes	No	Comment
Under the care of a psychiatrist			
Under the care of a counselor or therapist			

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PATIENT LABEL

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Surgical History****Only complete if new to Allina** ☐ I am an Allina patient

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominal surgery | <input type="checkbox"/> Cholecystectomy/gallbladder removal |
| <input type="checkbox"/> Hernia repair     | <input type="checkbox"/> Spine surgery                       |
| <input type="checkbox"/> Tubal ligation    | <input type="checkbox"/> Hysterectomy                        |

	Yes	No	Comment
Have you had problems with anesthesia?			

Weight Loss Surgery – complete this section **ONLY** if you have had weight loss surgery before

Open	Laparoscopic or Robotic	Comments
What year did you have weight loss surgery?		
Name of surgeon		Where:
Weight before surgery		Lowest weight after surgery
Any adverse events after surgery?		Describe:

Indicate which operation you had below and was the surgery ☐ open ☐ laparoscopic or robotic

<input type="checkbox"/> gastric bypass (Roux-en-Y)	<input type="checkbox"/> adjustable gastric band (Lap-band or Realize band)
<input type="checkbox"/> duodenal switch	<input type="checkbox"/> vertical banded gastroplasty (VBG)
<input type="checkbox"/> sleeve gastrectomy	<input type="checkbox"/> Other:

**Family History**

Is there a family history of:	Yes	No	Family member
Substance Abuse Dependence Type of Substance _____			
Depression			
Anxiety			
Severe mental illness			

**Substance Use**

	Yes	No	Type/Amount/Frequency
Do you currently use tobacco, marijuana, cannabis, THC, or edibles? <input type="checkbox"/> tobacco <input type="checkbox"/> vaping <input type="checkbox"/> e-cig			
How many years did you use?			
How much did you use?			Packs of cigarettes per day:
When did you quit?			

	Yes	No	Type/Amount/Frequency
Do you consume alcohol?			
Last consumed alcohol?			When:

	Yes	No	Type/Amount/Frequency
Have you ever used an illicit drug such as cocaine, meth, or heroin?			

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Social History

	Yes	No	Comment
Are you presently in a relationship?			If yes, for how long?
Do you have children?			What are their ages?
Are you currently employed?			If yes, how long have you been employed?
			Occupation:
Do you have stable housing?			Type:
Are you disabled?			Reason: Work status:
Are you sexually active?			If so, male or female partner?
Do you use birth control?			What method?

Female Reproductive

Some weight loss medications are known to cause birth defects. \*Use of contraception may be required in the medical program.

	Yes	No	Comment
Is there a possibility that you are pregnant?			
Are you planning future pregnancies?			
Are you currently breast feeding?			
Have you gone through menopause?			
Do you have a history of polycystic ovarian syndrome (PCOS)?			

What is the date that your last pregnancy was complete / date of delivery?	Date:
--	-------

STOP BANG

☐ I have sleep apnea and use a CPAP/BiPap      ☐ I have sleep apnea and do not use a CPAP/BiPap

If you have already been diagnosed with sleep apnea and have been prescribed a CPAP or BiPAP, you do NOT have to complete this section.

Collar size of shirt   ☐ S   ☐ M   ☐ L   ☐ XL   or \_\_\_\_\_ inches cm

Neck circumference \_\_\_\_\_ inches / cm

	Yes	No
Snoring – Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)		
Tired – Do you often feel tired, fatigued, or sleepy during the day?		
Observed – Has anyone observed you stop breathing during your sleep?		
Blood Pressure – Do you have or are you being treated for high blood pressure?		
BMI – BMI more than 35 kg/m²?		
Age – Age over 50 years old?		
Neck circumference – Neck circumference greater than 40 cm / 15.75 inches?		
Gender – Gender male?		



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Allergies

Only complete if new to Allina ☐ I am an Allina patient

List allergies to medicine, food, dye, tape, metal, latex.

Allergy	Reaction

Medications

Only complete if new to Allina ☐ I am an Allina patient

List **all current** medications you are taking including vitamins, over-the-counter medications, supplements, and intermittently used medications. Our goal is to validate your medications. Please do NOT write “see my chart”.

Name	Dose	How often taken	Purpose	Year started

Pharmacy of Choice – name the pharmacy you use to have your prescriptions filled.

Name of pharmacy	City/Location	Phone Number

Physical Activity

Indicate **past** exercise efforts:

<input type="checkbox"/> group exercise classes	<input type="checkbox"/> health club membership (YMCA, Curves, SNAP Fitness, etc.)
<input type="checkbox"/> use of a pedometer	<input type="checkbox"/> home exercise (videos, treadmill, etc.)
<input type="checkbox"/> personal trainer	<input type="checkbox"/> other – describe:

Describe **current** exercise program:

Type of exercise	
Frequency (number of days per week)	
Duration (number of minutes per session)	
If <b>not</b> exercising, what keeps you from exercising?	

Ability to Walk:

<input type="checkbox"/> no limitations	<input type="checkbox"/> Use of a brace	<input type="checkbox"/> Use of a cane	<input type="checkbox"/> Use of a walker	<input type="checkbox"/> Use of a Wheelchair
Are you able to walk 2 blocks?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you able to go up and down a flight of stairs?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Weight Loss History

Weight Loss Attempts – Indicate which diet programs you have tried in the past

Diet Program	
<input type="checkbox"/> Atkins diet	<input type="checkbox"/> Nutrisystem
<input type="checkbox"/> Cabbage soup	<input type="checkbox"/> Optifast
<input type="checkbox"/> Calorie counting	<input type="checkbox"/> Other high protein / low carbohydrate
<input type="checkbox"/> Diabetic diet	<input type="checkbox"/> Overeaters Anonymous
<input type="checkbox"/> Exercise	<input type="checkbox"/> Own reduced calorie / portions
<input type="checkbox"/> Grapefruit	<input type="checkbox"/> Registered Dietitian visits
<input type="checkbox"/> Jenny Craig	<input type="checkbox"/> Slimfast
<input type="checkbox"/> Ketogenic	<input type="checkbox"/> Slimgenics
<input type="checkbox"/> LA Weight Loss	<input type="checkbox"/> South Beach
<input type="checkbox"/> Low fat / low cholesterol	<input type="checkbox"/> TOPS
<input type="checkbox"/> MD supervised program	<input type="checkbox"/> Weight Watchers
<input type="checkbox"/> Medifast	<input type="checkbox"/> Zone
<input type="checkbox"/> New Day	<input type="checkbox"/> Other: _____

### Do you have a pattern or known causes of weight gain?

- ☐ Gradual over time
- ☐ Postpartum
- ☐ Depression or other significant life event Describe: \_\_\_\_\_
- ☐ Medication related. Name of medication: \_\_\_\_\_
- ☐ Sudden / unexpected Explain: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

Weight Loss Medications – Indicate which medications you have used or are currently using to lose weight

Medication		
<input type="checkbox"/> Fen-phen	<input type="checkbox"/> phentermine / topiramate (Qsymia)	
<input type="checkbox"/> liraglutide (Victoza or Saxenda)	<input type="checkbox"/> Redux (dexfenfluramine)	
<input type="checkbox"/> lorcaserin (Belviq)	<input type="checkbox"/> Semaglutide (Ozempic or Wegovy)	
<input type="checkbox"/> metformin (Glucophage)	<input type="checkbox"/> sibutramine (Meridia)	
<input type="checkbox"/> Mounjaro	<input type="checkbox"/> tirzepatide (Zepbound)	
<input type="checkbox"/> naltrexone HCL/Bupropion HCL (Contrave)	<input type="checkbox"/> topiramate (Topamax or Trokendi)	
<input type="checkbox"/> orlistat (Alli, Xenical)	<input type="checkbox"/> wellbutrin	
<input type="checkbox"/> phentermine	<input type="checkbox"/> Other	
	Yes	No
Did you take Fen-phen or Redux for longer than 3 months?		
If yes, did you have an echocardiogram?		
	Yes	No
Have you tried diet and exercise for a period of at least 3 months?		
Have you tried diet and exercise for a period of at least 6 months?		
Did you lose 1 pound or more a week while trying diet and exercise?		



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**Dietary Assessment**

Time:		Describe what you typically eat for each of the following:
Wake up?		
Eat breakfast?		
Eat snacks?		
Eat lunch?		
Eat snacks?		
Eat dinner?		
Eat snacks?		
Go to bed?		

**Dining Out History:**

How many times do you eat out each week?	
Where do you dine out?	
What foods do you order when you dine out?	

**Describe what you typically consume for liquids:**

	Type	Amount in ounces	Frequency		
Water			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Artificially sweetened water			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Diet soda			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Regular soda			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Milk			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Juice			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Other			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Coffee	<input type="checkbox"/> caffeine <input type="checkbox"/> decaf		<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Sugar	How much:				
Cream	How much:				
Tea	<input type="checkbox"/> caffeine <input type="checkbox"/> decaf		<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Sugar	How much:				
Cream	How much:				
Energy Drinks			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Sports Drinks			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Alcohol			<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly

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Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_



**Meal Activity:**

How long does it take you to eat a meal?	
Who does the grocery shopping?	
Who prepares the meals in your home?	

	Yes	No	Comment
Do you do any binge eating?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you eat until uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>	How often?
Do you eat when not physically hungry?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you worry that you have loss of control over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake at night to eat?	<input type="checkbox"/>	<input type="checkbox"/>	

**Medical Care Providers**

List all providers you receive care from, starting with your primary care provider. Include their area of specialty, addresses, and phone numbers.

Primary Care Provider: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Mental Health Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

**Appointment Policy**

We try to provide the best service possible to the clients we serve. To allow us to do this, it is important that you come for all of your scheduled appointments. If you need to cancel or reschedule, please contact our office at least 24 hours in advance. This allows us the opportunity to offer that appointment time to another patient who is waiting.

If you have three cancellations without 24 hours' notice or three no shows in one year, program services may be terminated. The Program Manager or Nurse Clinician will attempt to contact you to assess your ongoing interest and commitment to the program.

If you need to cancel or reschedule an appointment please contact the clinic where your appointment is scheduled.

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PATIENT LABEL

Patient Name: \_\_\_\_\_

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# INSURANCE VERIFICATION FORM

**Medicare Patients:** Be aware that Medicare and Medicare replacement plans do not cover dietitian visits. Medicare enrollees may be asked to sign a waiver acknowledging these visits may not be a covered service. The cost for the dietitian component of the program will be at least \$250.00

Patient Initials \_\_\_\_\_

You must contact your insurance company to determine your coverage for weight loss services. To do so, please call the customer service number on the back of your insurance card. Keep record of the date of your call as well as the name of the customer service representative who provided you the information.

If you are enrolling in the Surgical Program, we will contact your insurance carrier as well to verify your coverage and criteria for weight loss surgery. This is to ensure that all information provided to *you* and to *us* is accurate. In order to do this on your behalf, please complete the following:

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you had weight loss surgery in the past? ☐ Yes ☐ No

## INSURANCE INFORMATION

Primary Insurance:

Company: \_\_\_\_\_/ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance (If applicable):

Company: \_\_\_\_\_/ID# \_\_\_\_\_ Group# \_\_\_\_\_

If UCARE Insurance, what is the PMI number: \_\_\_\_\_

Are you the subscriber: ☐ Yes ☐ No

If not, Name of Subscriber, Date of Birth, and Relationship

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Social Security Number of Subscriber: \_\_\_\_\_ (Tricare and Veterans Insurance ONLY)

Provider Phone Number OR Customer Service Phone Number on the back of your insurance card: \_\_\_\_\_

## SURGICAL PATIENTS ONLY:

We will document the information we receive in your chart. This will be provided to your nurse clinician prior to your Initial Visit so that she can accurately determine a plan of care for you to meet your specific insurance criteria. If we determine that you **DO NOT have insurance coverage for weight loss surgery**, we will contact you. Please provide the best phone number to reach you and also indicate if we are able to leave a message for you at that phone number.

Phone: \_\_\_\_\_ Okay to Leave a Message: ☐ Yes ☐ No



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PATIENT LABEL

Patient Name: \_\_\_\_\_

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