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.

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.

PRINT RESET

Doc Type: Questionnaire
Descriptor: Bariatric

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 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:	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Medical History

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

Have you ever been diagnosed with:

☐ Depression	☐ Personality disorder
☐ Bipolar	☐ Compulsive overeating
☐ Anxiety / Panic attacks	☐ Anorexia Nervosa
☐ Schizophrenia	☐ Binge eating disorder
☐ Psychosis	☐ Bulimia
☐ Other / describe	

Check all that apply:

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

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Surgical History

☐ Abdominal surgery
☐ Hernia repair
☐ Tubal ligation
☐ Cholecystectomy/gallbladder removal
☐ Spine surgery
☐ 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

☐ gastric bypass (Roux-en-Y)	☐ adjustable gastric band (Lap-band or Realize band)
☐ duodenal switch	☐ vertical banded gastroplasty (VBG)
☐ sleeve gastrectomy	☐ 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, cannibis, THC, or edibles? ☐ tobacco ☐ vaping ☐ 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?	☐	☐	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

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 ***s***nore loudly (louder than talking or loud enough to be heard through closed doors?	☐	☐
Tired – Do you often feel ***t***ired, fatigued, or sleepy during the day?	☐	☐
Observed – Has anyone ***o***bserved you stop breathing during your sleep?	☐	☐
Blood Pressure – Do you have or are you being treated for high *b*lood ***p***ressure?	☐	☐
BMI – ***B***MI more than 35 kg/m^2?	☐	☐
Age – ***A***ge over 50 years old?	☐	☐
Neck circumference – ***N***eck circumference greater than 40 cm / 15.75 inches?	☐	☐
Gender – ***G***ender male?	☐	☐

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Allergies

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

Allergy	Reaction

Medications

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:

☐ group exercise classes	☐ health club membership (YMCA, Curves, SNAP Fitness, etc.)
☐ use of a pedometer	☐ home exercise (videos, treadmill, etc.)
☐ personal trainer	☐ other – describe:

Describe **current** exercise program:

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

Ability to Walk:

☐ no limitations	☐ Use of a brace	☐ Use of a cane	☐ Use of a walker	☐ Use of a Wheelchair
Are you able to walk 2 blocks?			☐ Yes ☐ No	
Are you able to go up and down a flight of stairs?			☐ Yes ☐ No	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Weight Loss History

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

Diet Program	
☐ Atkins diet	☐ Nutrisystem
☐ Cabbage soup	☐ Optifast
☐ Calorie counting	☐ Other high protein / low carbohydrate
☐ Diabetic diet	☐ Overeaters Anonymous
☐ Exercise	☐ Own reduced calorie / portions
☐ Grapefruit	☐ Registered Dietitian visits
☐ Jenny Craig	☐ Slimfast
☐ Ketogenic	☐ Slimgenics
☐ LA Weight Loss	☐ South Beach
☐ Low fat / low cholesterol	☐ TOPS
☐ MD supervised program	☐ Weight Watchers
☐ Medifast	☐ Zone
☐ New Day	☐ 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	
☐ Fen-phen	☐ phentermine / topiramate (Qsymia)
☐ liraglutide (Victoza or Saxenda)	☐ Redux (dexfenfluramine)
☐ lorcaserin (Belviq)	☐ Semaglutide (Ozempic or Wegovy)
☐ metformin (Glucophage)	☐ sibutramine (Meridia)
☐ Mounjaro	☐ tirzepatide (Zepbound)
☐ naltrexone HCL/Buproprion HCL (Contrave)	☐ topiramate (Topamax or Trokendi)
☐ orlistat (Alli, Xenical)	☐ wellbutrin
☐ phentermine	☐ 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?	☐	☐

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

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			☐ Daily	☐ Weekly	☐ Monthly
Artificially sweetened water			☐ Daily	☐ Weekly	☐ Monthly
Diet soda			☐ Daily	☐ Weekly	☐ Monthly
Regular soda			☐ Daily	☐ Weekly	☐ Monthly
Milk			☐ Daily	☐ Weekly	☐ Monthly
Juice			☐ Daily	☐ Weekly	☐ Monthly
Other			☐ Daily	☐ Weekly	☐ Monthly
Coffee	☐ caffeine ☐ decaf		☐ Daily	☐ Weekly	☐ Monthly
Sugar	How much:				
Cream	How much:				
Tea	☐ caffeine ☐ decaf		☐ Daily	☐ Weekly	☐ Monthly
Sugar	How much:				
Cream	How much:				
Energy Drinks			☐ Daily	☐ Weekly	☐ Monthly
Sports Drinks			☐ Daily	☐ Weekly	☐ Monthly
Alcohol			☐ Daily	☐ Weekly	☐ Monthly

PATIENT LABEL

Patient Name: _____

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?	☐	☐	
Do you eat until uncomfortably full?	☐	☐	How often?
Do you eat when not physically hungry?	☐	☐	
Do you worry that you have loss of control over how much you eat?	☐	☐	
Do you wake at night to eat?	☐	☐	

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.

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