Patient Health Questionnaire

Please print and complete PRIOR to the first visit with Dr. Anegawa.
You may email your completed form to info@anegawamd.sprucecare.com (preferred) or you may bring to the visit.
Please also bring any blood test results done in the last one year.

Legal Name _____ Social Security#____--____-_____
I prefer to be called: _____
Address: _____
City/State: _____ Zip:_____
Home Phone: _____ Cell: _____ OK to leave confidential voicemail? Y N

Email: _____
Date of Birth _____/_____/_____ Age: _____

Marital Status: S M W D
Occupation: _____

Primary Physician: _____
Primary physician phone #: _____/ fax #: _____
Preferred Pharmacy:_____

Please list your main reasons for consultation (weight loss, better health, athletic performance, etc):

WEIGHT HISTORY

Age your weight gain started (circle): childhood puberty teens adulthood

Circle influences on weight gain:
Pregnancy
An injury
A life event
A traumatic event
Other/more details:

Your lifetime (non-pregnant) max weight: _____ pounds (lbs)

Your lowest adult weight: _____ pounds
Your goal weight: _____
Were you ever at your goal weight: Y N If so, when? _____
What was your weight 1 year ago? _____

What have you done in the past to try to lose weight? Circle all that apply:

Atkins Clean Eating Diet Pills Dietitians Hypnosis Exercise HCG
Health Coaching Ideal Protein Intermittent fasting Jenny Craig Keto Low Carb Meal Prepping Medifast Nutritionist Bariatric Surgery NutriSystems Optavia Optifast Overeaters Anonymous Paleo Purging/Vomiting Starvation Weight Watchers

Other methods/additional details on the above:

Behavior/Lifestyle: Which of the following best describes you? Please circle ALL that apply:

Lack of time for self
Difficulty prioritizing my own personal needs over demands of work/family
High stress levels
Problems sleeping or not feeling rested
Low energy/fatigue

Emotional eating (with anger, sadness, loneliness, etc)
Stress eating
Social eating (only eat excessively at social events with friends)
Waking up to eat in the middle of the night
Weekend overeating

Eating too late at night
Eating too fast

Always hungry
Rarely hungry

Mindless eating/habit eating
Boredom eating

Food cravings
Food dominates my life
Eating until uncomfortably full (Thanksgiving day stuffed on a regular basis)
Large Portions
Skipping meals

I consume liquid calories/sugar such as alcohol, juice, energy drinks, or sodas

How would you rate your readiness for lifestyle changes to reduce your weight?
Please circle: Lowest 1 2 3 4 5 Highest

Would you be willing to keep a food journal? Y N
How confident are you that you can lose weight at this time?
Low 1 2 3 4 5 High
How supportive is your family for your weight loss goals?
Low 1 2 3 4 5 High
How supportive are your friends for your weight loss goals?
Low 1 2 3 4 5 High
How often do you eat out (anywhere, including convenience foods, fast foods, fine dining)? Please circle:
Rarely 1-2 times/week 3-5 times/week Daily

Please list everything you ate/drank for 24 hours:

Exercise History (What you are doing right now)
Type: Walking Biking Swimming Other:_____
What is your frequency?

Your intensity?

How long?

Do you perform any resistance type exercise (weight lifting or strength training)?
Y N
Do you use a device to monitor your exercise (Fit Bit or Pedometer)? Y N
Do you have or use a scale? Y N
Do you have any disabilities or injuries that affect your ability to exercise? Y N

MEDICAL HISTORY

Current Meds including Supplements/Herbs – List Name and Dose:

Please list Any Major Surgery (including weight loss surgery) and dates:

Any known drug allergies?

Please circle the medical conditions that YOU have been diagnosed with in the past or currently:

High Blood Pressure
High Cholesterol
Heart Disease/Heart Failure
History of Heart Attack
Syncope(passing out)
History of Long QT syndrome
Pacemaker or Defibrillator
History of Heart Valve problems or Arrhythmia

Asthma
COPD
Sleep apnea
Insomnia

Heartburn/GERD
Liver disease including fatty liver

Kidney disease
Kidney stones

Osteoarthritis
Rheumatoid arthritis
Gout
Other muscoloskeletal issues: _____

Stroke or TIA
Migraines
Seizures
Numbness

Drug use
Marijuana use
Bipolar Disorder
ADHD
Schizoaffective disorder
Eating disorders: Anorexia Nervosa Bulimia Binge eating disorder Night Eating disorder

Prediabetes
Diabetes (complications? _____ checking blood sugar? _____)

Cancer (type): _____

Please list any additional health information that we should know about you:

Do you smoke cigarettes? Y N Marijuana? Y N Vaping? Y N
Drink Alcohol? Y N How much? _____/day or week

Has any blood relative ever had any of the following? Please circle:

Unexplained death<40 years Heart Attack Cancer High Blood Pressure Heart Disease Stroke Mental Illness Diabetes or "borderline diabetes" Overweight Kidney Disease Drug abuse Alcohol abuse Asthma High Cholesterol

Current Symptoms – Circle ANY that you have had in the last 2 weeks

Fatigue
Night sweats
Fever > 100

Skin rashes
Eczema
Acne
Dry skin

Tooth problems
Mouth sores
Allergies/sinus issues/congestion

Shortness of breath
Wheezing
Cough
Snoring
Coughing/choking/gasping in sleep
Feeling tired despite adequate sleep
Insomnia

Chest pain
Palpitations

Nausea
Vomiting
Abdominal pain
Diarrhea
Constipation

Pain with urination
Urinary frequency
Urinary incontinence

Weakness
Numbness
Tingling
Vertigo
Headaches or migraine

Joint pains
Joint swelling
Difficulty walking

Anxiety
Depression

WOMEN: Are your periods regular? Y N If not, do you skip periods? Y N
Infertility Y N Unwanted hair? Y N
Are you Pregnant? Y N
Breastfeeding? Y N
Do you plan on becoming pregnant in the next few months?
Birth control method (includes male or female sterilization):

_____

MEN: Muscles Weak? Y N Low Sex Drive? Y N Erectile Dysfunction? Y N Low Energy? Y N