GOAL Family Medical P.C.
Compassion. Dedication. Trust.

Non-surgical Weight Loss Questionnaire

Full Name ____________________ DOB ___/___/___ Contact Phone ________________

Non surgical weight loss - comprehensive lifestyle modifications along with medication

1. Have you tried any weight loss programs or methods in the past?

○ Yes, List ___________________ ○ No

2. Do you have any underlying medical conditions? Please select all that apply

○ Diabetes ○ Heart disease ○ High Blood Pressure

○ Thyroid disorders ○ Joint problems (arthritis, spondylosis, scoliosis)

○ Sleep apnea ○ Autoimmune disorders

Other medical conditions (please specify): _____________________

3. Are you currently taking any medications?

○ Yes, List ____

○ No

4. Have you ever had weight loss surgery or any other surgical procedures related to weight loss?

○ Yes, List ____

○ No

5. Please indicate your level of commitment and interest in the following components of our weight loss plan:

a. Lifestyle modification (diet & regular exercise) with medication management:

○ Very interested and committed

○ Interested but unsure of commitment

○ Not interested

Thank you for completing the questionnaire. Please return this form to the front desk or hand it to your healthcare provider during your appointment.

Dr. Ogadinma McGeachy
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