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Bariatric & Preventive Medicine  
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**GENERAL HEALTH**

1. Do you consider your health to be:    \_\_\_Excellent    \_\_\_Good    \_\_\_Poor

2. Medical conditions

Please check any of the following conditions you have currently or had in the past and when they were first diagnosed:

\_\_\_ Thyroid condition: \_\_\_\_\_

\_\_\_ Prior stroke or Transient Ischemic Attack (TIA): \_\_\_\_\_

\_\_\_ Heart disease, Heart attack: \_\_\_\_\_

\_\_\_ Depression: \_\_\_\_\_

\_\_\_ Anxiety: \_\_\_\_\_

\_\_\_ Binge Eating: \_\_\_\_\_

\_\_\_ Substance use/dependence (stimulants, sedatives, etc): \_\_\_\_\_

\_\_\_ Currently pregnant or nursing or planning to become pregnant

\_\_\_ Other: \_\_\_\_\_

3. Any surgeries in the past year (including bariatric surgery)? Y/N If yes, type: \_\_\_\_\_

4. Do you take any medications or nutritional or herbal supplements? Y/N If yes, which ones? \_\_\_\_\_

5. Family History of excess weight (especially mother and/or father)? Y/N If yes, who? \_\_\_\_\_

6. Do you have any allergies (to medications, foods, environmental items)? Y/N If yes, to what and what reaction to you get? \_\_\_\_\_

**LIFESTYLE AND HABITS**

Do you like to exercise? Y/N    Exercise regularly now? Y/N    If yes, how often, for how long? \_\_\_\_\_

Do you drink alcohol? Y/N    If yes, daily amount? \_\_\_\_\_

Do you smoke cigarettes? Y/N    If yes, daily amount? \_\_\_\_\_

**PREVIOUS WEIGHT LOSS ATTEMPTS AND RESULTS**

Approximate weight \_\_\_\_\_ height \_\_\_\_\_ Desired weight \_\_\_\_\_ When were you at this weight last? \_\_\_\_\_

Previous weight loss experience and results:

**GOALS**

What are 3 ways that your life would be better if you had a healthier weight? Why do you want to work on this now?

Lastly, may we ask how you heard about Dr. Bera-Miller? \_\_\_\_\_

*Thank you for completing this form and bringing it to your Initial Consultation. See you soon!*