

# Health Questionnaire



Your patient would like to join the LighterLife Total weight-management programme. This offers the obese or those with a raised waist circumference a nutritionally complete very-low-calorie diet (VLCD), providing 500-600 kcal and a minimum of 50g of carbohydrate per day. Patients also attend weekly group meetings which use techniques from cognitive behavioural therapy and transactional analysis to support behaviour modification necessary for sustainable weight management. LighterLife Total is compliant with NICE guideline 43 on the treatment of obesity. Thank you very much for your time.

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Your patient \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Postcode \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Waist circumference \_\_\_\_\_ cm  
 Email \_\_\_\_\_ BMI \_\_\_\_\_

Counsellor cohort ID \_\_\_\_\_ Client CIF number \_\_\_\_\_

### 1. The 'yes' boxes in this section are exclusion criteria for LighterLife Total.

#### Has your patient experienced:

- Epilepsy, seizures, convulsions
- Type 1 diabetes
- Porphyria
- Total lactose intolerance
- Heart failure, arrhythmia, valve disease requiring treatment
- Schizophrenia and delusional disorder, psychotic episode, bi-polar disorder
- Major depressive disorder
- Severe renal / liver disease
- Current active anorexia, bulimia or currently undergoing treatment for any other eating disorder

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

### 2. The 'yes' boxes in this section may exclude your patient from participating in LighterLife Total.

#### Has your patient had:

Yes	No	Date	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	dd mm yy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombosis or treatment for thrombosis in the last six months			Is the condition stable?		I agree to monitor my patient during the VLCD	
<input type="checkbox"/>	<input type="checkbox"/>	dd mm yy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebrovascular disease			Is the condition stable?		I agree to monitor my patient during the VLCD	
<input type="checkbox"/>	<input type="checkbox"/>	dd mm yy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac disease, including angina and MI			Is the condition stable?		I agree to monitor my patient during the VLCD	

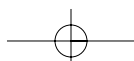
### 3. Has your patient had:

Yes	No	Details	Date
<input type="checkbox"/>	<input type="checkbox"/>	_____	dd mm yy
Any serious illness, injury, trauma and / or surgery in the last three months			
Yes	No	Details	Date
<input type="checkbox"/>	<input type="checkbox"/>	_____	dd mm yy
Is your patient: Undergoing or due to undergo any course of treatment (see over for medication) / surgery / investigation / referral			

### 4. Please indicate any other significant medical history

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Blood pressure and pulse rate:** BP \_\_\_\_\_ Pulse rate \_\_\_\_\_  
 Is the pulse rate regular? Yes  No  If irregular, does the patient require treatment / investigation? Yes  No



## WOMEN ONLY

Please answer **EVEN** if the questions below seem irrelevant to your patient (eg post-menopausal)

	Yes	No	If yes	Date
Is the patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Has the patient given birth in the last three months?	<input type="checkbox"/>	<input type="checkbox"/>	When was the baby born?	dd mm yy
Is the patient breastfeeding as the baby's main form of nutrition?	<input type="checkbox"/>	<input type="checkbox"/>		
Has the patient miscarried at more than 20 weeks' gestation?	<input type="checkbox"/>	<input type="checkbox"/>	When was the miscarriage?	dd mm yy

## MEDICATIONS

### Oral hypoglycaemic/insulin medication

The LighterLife Total VLCD provides 500-600 kcal and a minimum of 50g CHO per day, which will reduce plasma glucose levels. Type 2 diabetics will require planned review of hypoglycaemic agents and insulin, which are usually reduced or stopped at the commencement of the LighterLife Total VLCD.

Name \_\_\_\_\_ Dose \_\_\_\_\_ Date started \_\_\_\_\_  
 Name \_\_\_\_\_ Dose \_\_\_\_\_ Date started \_\_\_\_\_

### Anti-hypertensive medication

Blood pressure can reduce with weight loss and medication will require review and titration.

Name \_\_\_\_\_ Dose \_\_\_\_\_ Date started \_\_\_\_\_  
 Name \_\_\_\_\_ Dose \_\_\_\_\_ Date started \_\_\_\_\_

### Diuretic medication

This restricted-carbohydrate VLCD initiates an increased natural diuresis. It is likely your patient will also consume additional fluids to replace those found in conventional food. In combination with diuretic medication, this can potentially disturb electrolyte equilibrium. Diuretic medication will require review.

Name \_\_\_\_\_ Dose \_\_\_\_\_ Date started \_\_\_\_\_

### Other prescribed medication

Name	Dose	Indication	Date started
			dd mm yy
			dd mm yy
			dd mm yy
			dd mm yy
			dd mm yy

**This questionnaire allows LighterLife to ascertain your patient's medical status and operate exclusion criteria. In signing this form you confirm that the information provided is true to the best of your knowledge. It does not transfer medical responsibility for LighterLife Total to you, your practice or your employer. Your patient is aware that you may levy a charge for this service and, where a fee is charged, your patient will pay you directly.**

## DOCTOR / PRACTICE NURSE SIGNATURE

Please confirm by signing this form that you are aware medication monitoring / adjustment may be required and that, where appropriate, you will arrange this with your patient during the LighterLife Total VLCD.

Doctor's / practice nurse's signature \_\_\_\_\_  
 (Delete where appropriate)

Please print name \_\_\_\_\_

Date \_\_\_\_\_

Please confirm whether this is the patient's registered surgery

Yes  No

### Surgery stamp

All medical information on this form is for LighterLife UK Limited use only. LighterLife UK Limited complies with the Data Protection Act.

## PATIENT SIGNATURE

I confirm that the information on this form is correct and accurate and no material information has been omitted. If I become aware that any of the information in this form is incorrect or out of date, I will inform my LighterLife Counsellor immediately. I authorise the release of this form to my LighterLife Counsellor and to LighterLife Central Office.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_