In Balance

Female Focused Weight Loss

DunneWithDieting.com

Dear Patient,

Thank you for your interest in our medically supervised weight loss program.

Please fill out the following intake form and return it to the office before you schedule your first visit

- Fax (914) 948-1019 Attention: Dawn
- Attach to email: dcastelli@westmedgroup.com

This intake form has two purposes

1. Identify codes we can **submit** to your insurance company
   - Insurance companies do not generally cover weight loss per se
   - However, they will cover the "co-morbidities" associated with excess weight
   - If your BMI is greater than 30, they should cover unless you have an "obesity exclusion"
   - They may also cover if your BMI is greater than 27 with more than one co-morbidity

2. Identify issues you have been struggling with in your efforts to lose and maintain a healthy weight and lifestyle
   - This information will provide the supporting documentation that your insurance company requires to cover these services

After we receive your completed forms, we will provide you with the ICD and CPT codes that you can use to contact your insurance company to check coverage. These visits are billed as "**problem visits**" (as they are not considered *preventative*) so they may be subject to a **co-pay** or **deductible**. These visits do NOT require pre-authorization from our office. We simply suggest you check with your insurance ahead of time regarding possible out-of-pocket expenses. Also, if you discover that you have an obesity exclusion please let us know.

To **schedule, cancel** or **reschedule** your appointments, **please contact Dawn directly** at dcastelli@westmedgroup.com. If you prefer to call the office, please leave a message for Dawn to call you back at (914) 848-8668 otherwise your appointment may not be scheduled correctly and may need to be rescheduled. DO NOT SCHEDULE THROUGH ON-LINE BOOKING.

Please be courteous of our scheduling procedures.

If you are unable to keep your appointment please contact the office within 24 hours to cancel.

We understand that "things come up" but please take the time to reach out to us. This will allow sufficient time for another patient to schedule their appointment. Please read and sign our cancellation/no show policy below.

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Cancellation/No Show Policy

We understand there may be times when you will need to cancel an appointment with our office. If you are unable to keep your appointment please notify our office at least 24 hours in advance to cancel or reschedule. Please email **Dawn** directly at dcastelli@westmedgroup.com OR call (914) 848-8668 and leave a message for **Dawn**.

Please be courteous to other patients who may want your scheduled time for their appointment as well as to our providers who block a significant amount of time for your visit.

Patients that do not arrive for a scheduled appointment or cancel an appointment less than 24 hours prior to the scheduled appointment time will be subject to the following:

1. Charged 50% of our self-pay fee schedule regardless if they are self-pay or eligible for insurance.

   1st Consultation self-pay fee: $250.00
   No Show fee: $125.00

   Follow-Up Visit self-pay fee: $135.00
   No Show fee: $67.50

OR

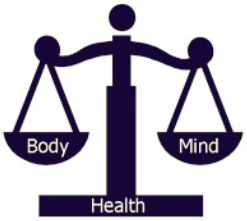
2. Discharged from our weight management program. We are interested in caring for patients who are invested in their health and this includes being responsible for appointments.

To cancel or reschedule your appointment, please reach out DIRECTLY to Dr. Dunne's medical assistant, **Dawn**. Please email **Dawn** at dcastelli@westmedgroup.com. If you prefer to call the office, please leave a message for **Dawn** to call you back at (914) 848-8668; otherwise, your appointment may not be cancelled or rescheduled correctly and you may be subject to the cancellation policy.

By your signature below, you acknowledge that you understand the contents of this document.

Thank you in advance for your cooperation.

Name _____ Signature _____ Date _____



In Balance
Female Focused Weight Loss
DunneWithDieting.com
Julianne Dunne, MD
Lisa Luehman, NP

Date _____
Name _____
Date of Birth _____
Age _____

Height _____
Current Weight _____
Goal Weight _____
Referred by _____

What is your **expectation** from this program? *Choose the best one or write in your own*

○ to learn more about nutrition so I can make better food choices
○ to be assigned a specific dietary plan
○ to take a medication to help reduce my appetite and control cravings
○ to use meal replacements to expedite my weight loss
○ other _____

What are your weight loss goals? *Check all that apply*

○ to feel better
○ to become more active
○ to decrease the current medications I take
○ to increase my knowledge of health and nutrition
○ to achieve a specific weight target
○ other _____
○ to improve my health
○ to improve my mobility
○ to decrease my risk of disease
○ to optimize my health for future pregnancy
○ I do not have any goals at this time

Weight loss barriers

Which of the following factors are keeping you from achieving your weight loss goals? *Check all that apply*

○ hunger
○ hormonal issues
○ finances
○ social events
○ hectic daily schedule
○ aging
○ other _____
○ cravings
○ physical limitations
○ other medications
○ eating habits of others
○ lack of time
○ lack of knowledge about nutrition
○ stress
○ frequent travel
○ lack of social support
○ other medical issues
○ slow metabolism
○ family obligations

Did any of the following life events contribute to your weight gain? *Check all that apply*

○ personal illness or disability
○ pregnancy
○ marriage
○ other _____
○ stressful job
○ psychological event
○ menopause
○ divorce
○ taking care of ill family member
○ new medication

Readiness to Change

Importance of change. How **important** is it for you to change your diet and lifestyle habits to lose weight?

(low importance) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (high importance)

Readiness to change. How **ready** are you to change your diet and lifestyle habits to lose weight?

(low importance) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (high importance)

Confidence in your ability to change. How **confident** are you in your ability to change?

(low importance) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (high importance)

Medical History

Primary care physician _____ Date last seen _____

Check all the **medical** issues that apply to you:

○ high blood pressure	○ stroke	○ insulin resistance	○ sleep apnea	○ autoimmune disorder
○ high cholesterol	○ fatty liver disease	○ diabetes	○ asthma	○ depression
○ high triglycerides	○ gastric reflux	○ thyroid disorder	○ osteoarthritis	○ anxiety
○ heart disease	○ eating disorder	○ PCOS	○ gout	○ cancer

○ other _____

PLEASE send you recent bloodwork if your provider is a non-Westmed physician

Do you currently take any **medication** on a regular basis? *Include over-the-counter medications, vitamins and herbal remedies*

Drug name	Dosage	How often?	Purpose	Prescribing doctor

Are you **allergic** to any medications? ○ no known drug allergies ○ seasonal allergies

Drug name			
_____	○ rash or hives	○ swelling of lip or tongue	○ anaphylaxis
_____	○ rash or hives	○ swelling of lip or tongue	○ anaphylaxis
_____	○ rash or hives	○ swelling of lip or tongue	○ anaphylaxis

List past **surgeries** or **hospitalizations**.

Year	Surgical procedure or reason for hospitalization	Year	Surgical procedure or reason for hospitalization

Family History

Was your **mother** overweight at your conception? ○ yes ○ no during your childhood? ○ yes ○ no
Was your **father** overweight at your conception? ○ yes ○ no during your childhood? ○ yes ○ no

mother	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
father	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
sisters or brothers	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
daughters or sons	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
aunts	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
uncles	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
grandmother	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer
grandfather	○ hypertension	○ high cholesterol	○ heart disease	○ diabetes	○ stroke	○ dementia	○ cancer

Do you have family history of depression, anxiety, or other mental illness?

If yes, which family member(s)? _____

Please describe _____

Gynecologic History

If you are in your reproductive years, when was the 1st day of your last period?_____

Are your periods regular? ○ yes ○ no **Describe**: ○ less than 21 days apart ○ every 21-35 days ○ greater than 35 days apart

For how many days? ○ < 4 days ○ 4-7 days ○ >7 days **Describe**: ○ light ○ moderate ○ heavy ○ heavy with clots

Do you experience **premenstrual symptoms**? ○ yes ○ no If yes, do symptoms interfere with your daily activities? ○ yes ○ no

Have you ever been diagnosed with **infertility**? ○ yes ○ no

If yes, did you undergo fertility treatment? ○ yes ○ no Was it successful? ○ yes ○ no

If in menopause, what year was your last period? _____

Are you having? ○ hot flashes ○ irritability ○ vaginal dryness ○ painful intercourse ○ difficulty sleeping

Are you taking hormone replacement therapy (HRT)? ○ yes ○ no Have you ever taken HRT in the past? ○ yes ○ no

Are you currently **sexually active**? ○ yes ○ no

If yes, are you currently **planning pregnancy?** ○ yes ○ no

If you are **not planning** pregnancy, which of the following methods are you using? ○ **none**

○ condoms ○ pills ○ Nuvaring ○ depo-provera ○ Nexplanon ○ Mirena ○ Skyla ○ Kyleena ○ Paragard ○ vasectomy ○ tubal ligation

	Date performed	Results	Doctor
Last Pap smear			
Last mammogram			
Last colonoscopy			
Last bone density			

Obstetric History

How many times have you been **pregnant**?_____ How many **live births**?_____

If you have children, were they delivered by ○ vaginal birth ○ cesarean delivery ○ both

Have you ever experienced any adverse obstetrical outcomes? ○ gestational diabetes ○ gestational high blood pressure ○ pre-eclampsia ○ pre-term delivery (<36 weeks) ○ low birth weight baby <2500 grams (5lbs 8oz)

Are you currently **breastfeeding**? ○ yes ○ no If not currently, did you breastfeed any of your children? ○ yes ○ no

Social History

Marital status: ○ single ○ married ○ widowed ○ divorced ○ separated

Who lives at home with you? _____

What is your occupation? _____

Describe: ○ desk job ○ stand on feet often ○ heavy lifting

Describe your **commute** to work: ○ drive ○ take public transportation ○ walk to work ○ bike to work ○ work from home

Do you smoke **cigarettes**? ○ never ○ former smoker ○ current smoker ○ e-cigarettes/vape

If a **former/current** smoker, how many packs per day (ppd)? ○ <1 pack per day (ppd) ○ 1 ppd ○ 1-2 ppd ○ >2 ppd

How many total years have you/did you smoke? _____

Do you drink **alcohol**? ○ 0-12 drinks/year ○ 1-13 drinks/month ○ 4-14 drinks/week ○ >2 drinks/day

If yes, ○ beer ○ wine ○ liquor (on the rocks or with club soda) ○ cocktails (liquor with juice or tonic)

Have you ever been treated for **alcohol abuse?** ○ currently ○ recovered alcoholic ○ never

Do you have **family history** of alcohol abuse? ○ yes ○ no

Do you currently use or have you used **recreational drugs?** ○ yes ○ no

If yes, please list _____

Have you ever been treated for **drug abuse?** ○ yes ○ no

Do you have **family history** of drug abuse? ○ yes ○ no

Are you a survivor of or currently undergoing:

Physical abuse? ○ yes ○ no

Emotional abuse? ○ yes ○ no

Sexual abuse? ○ yes ○ no

If yes, have you undergone counseling? ○ yes ○ no

If no, would you like to be referred for counseling? ○ yes ○ no

Diet History

1. At what age did you first start gaining weight?_____
2. Which of the following commercial **weight loss programs** have you tried? ○ none

	Pounds lost	Length of participation	Why it worked/why it didn't work
○ Weight Watchers			
○ Nutrisystem			
○ Jenny Craig			
○ Liquid diet			
○ Overeaters anonymous			
○ other_____			

3. Which of the following weight loss **medications** have you tried? ○ none

	Pounds lost	Length of participation	Why it worked/why it didn't work
○ phentermine ○ Qsymia			
○ Belviq			
○ Contrave			
○ Saxenda			
○ Orlistat			

4. Which of the following **popular diets** have you tried? ○ none

	Pounds lost	Length of participation	Why it worked/why it didn't work
○ Atkins			
○ ketogenic			
○ Mediterranean			
○ Paleo			
○ Vegan ○ Vegetarian			
○ other_____			

5. Do you eat for the following **reasons**?

Self-reward	○ no	○ sometimes	○ yes
Stressed	○ no	○ sometimes	○ yes
Angry	○ no	○ sometimes	○ yes
Depressed	○ no	○ sometimes	○ yes
Nervous or worried	○ no	○ sometimes	○ yes
Lonely	○ no	○ sometimes	○ yes

Food Triggers

1. What triggers you to overeat? *Check all that may apply*
   ○ stress ○ boredom ○ comfort ○ eating certain foods ○ other_____
2. When you eat certain foods, can you easily stop?
   ○ yes ○ no
3. Are you compelled to eat until all the food is gone?
   ○ yes ○ no
4. If you have certain foods in your immediate environment, do you feel you must eat them?
   ○ yes ○ no
5. Are you easily full?
   ○ yes ○ no
6. Do you feel less panicky or feel relief after eating?
   ○ yes ○ no
7. Do you have difficulty resisting temptations?
   ○ yes ○ no

Julianne Dunne, MD ⌘ westmed ✉ 3030 Westchester Avenue Suite 202 ★ Purchase, NY 10577 ☏ (914) 848-8668

Eating Pattern Questionnaire

1. Do you follow a **special** diet?
   ○ no ○ low fat ○ low sodium ○ Kosher ○ vegetarian ○ diabetic ○ gluten-free ○ other_____

2. Which **meals** do you regularly eat? *Check all that may apply*
   ○ breakfast ○ lunch ○ dinner

3. Do you usually **snack?** *Check all that may apply*
   ○ never ○ morning ○ afternoon ○ evening ○ late night ○ throughout the day

4. How often do you **eat out** or **order take out?**
   ○ never ○ 1-2x/week ○ 3-5x/week ○ 6-7x/week ○ daily

5. Do you eat **fast food?**
   ○ no ○ sometimes ○ often

6. How is your food usually **prepared?** *Check all that may apply*
   ○ raw ○ baked ○ boiled ○ broiled ○ fried ○ grilled ○ microwaved ○ poached ○ steamed

7. Do you eat **after 7pm?**
   ○ no ○ sometimes ○ often

8. What **beverages** do you drink daily and how much?
   ○ water ____ glasses per day (8 oz.)
   ○ coffee ____ cups per day (8 oz.)
   What do you add to your coffee? _____
   ○ tea ____ cups per day (8 oz.)
   What do you add to your tea? _____
   ○ soda ____ servings per day (12 oz.) ○ regular soda ○ diet soda
   ○ juice ____ servings per day (8 oz.)
   ○ alcohol ____ glasses per day (12 oz. beer, 5 oz. wine, 1.5 oz. liquor)

9. What do you think is your biggest **challenge** to losing weight? *Check all that may apply*
   ○ Portion control
   ○ Snacking when bored
   ○ Emotional or stress snacking
   ○ Not feeling full after a healthy portion
   ○ Not eating the right foods due to personal food preferences or lack of time

time of day	**give me an idea of what you are eating in a typical day, including beverages!**

Julianne Dunne, MD ⌘ westmed ✉ 3030 Westchester Avenue Suite 202 ★ Purchase, NY 10577 ☏ (914) 848-8668

Physical Activity

Do you **exercise** regularly now? ○ yes ○ no

If yes,

- ○ Which activities? _____
- ○ How many times per week? _____
- ○ How long is each workout? _____

If no, what keeps you from exercising? *Check all that may apply*

- ○ No time
- ○ Too expensive
- ○ Gym/classes are too intimidating
- ○ Physical impairment
- ○ Don't like to sweat

What activities have you done in the past? _____

What activities would you be willing to try? _____

Inactivity

How many hours a day do you spend **watching** TV, Netflix, etc.?

○ 0 ○ 1-2 ○ 3-5 ○ 6-8 ○ 9-11 ○ 12 or longer

How many hours a day do you spend **sitting** at a desk or at a computer?

○ 0 ○ 1-2 ○ 3-5 ○ 6-8 ○ 9-11 ○ 12 or longer

Physical Activity Readiness Questionnaire (PARQ)

1. Has your doctor ever said that you have a heart condition and they you should only do physical activity recommended by a doctor
   ○ yes ○ no
2. Do you feel pain in your chest when you do physical activity?
   ○ yes ○ no
3. In the past month, have you had chest pain when you were not doing physical activity?
   ○ yes ○ no
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
   ○ yes ○ no
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
   ○ yes ○ no
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
   ○ yes ○ no
7. Do you know of any other reason why you should not do physical activity?
   ○ yes ○ no

Would you like to be referred for a physical fitness evaluation with our physical therapy department?

○ yes ○ no

Hormone Balance Questionnaire

Read carefully through the list of symptoms. Some may overlap between sections. Fill in circle (●) next to any you experience.

EXCESS CORTISOL

- ○ My life is crazy stressful
- ○ I feel overwhelmed by stress
- ○ I have extra weight around my midsection
- ○ I have difficulty falling or staying asleep
- ○ My body is tired at night, but my mind is going a mile a minute (wired but tired)
- ○ I get a second wind at night that keeps me from falling asleep
- ○ I feel easily distracted, especially when under stress
- ○ I get angry quickly or just feel on edge
- ○ I have high blood pressure or a fast heart rate
- ○ I have elevated blood sugar (insulin resistance) or diabetes
- ○ I get shaky if I don't eat often
- ○ I am prone to injury and have difficulty healing

Total_____

CORTISOL DEFICIENCY

- ○ I feel tired in the morning, even after a full night's sleep
- ○ I depend on caffeine to get through my day
- ○ I want to take naps most days
- ○ My energy crashes in the afternoon
- ○ I crave salty or sweet food
- ○ I am dizzy when I stand up too quickly
- ○ I feel at the mercy of stress
- ○ I have difficulty falling asleep and/or staying asleep
- ○ My muscles feel weaker
- ○ I get sick often and/or have a difficult time getting
- ○ I have low blood sugar issues

Total_____

ESTROGEN DOMINANCE

- ○ I experience bloating or puffiness
- ○ I feel irritable or experience mood swings
- ○ I experience heavy, painful periods
- ○ I have gained weight or have difficulty losing weight, especially around my hips, butt, and thighs
- ○ I have been told I have fibroids
- ○ I sometimes cry over nothing
- ○ I get migraines or other headaches
- ○ I have brain fog
- ○ I have gallbladder problems or have had my gallbladder removed

Total_____

ESTROGEN DEFICIENCY

- ○ I am emotionally fragile and/or feel nostalgic about the past
- ○ I have difficulty with memory
- ○ My periods are fewer than 3 days
- ○ I struggle with depression, anxiety or lethargy
- ○ I have night sweats or/or hot flashes
- ○ I have trouble with recurrent bladder infections
- ○ My breasts are smaller and/or beginning to droop
- ○ I have achy joints or am prone to joint injuries
- ○ My sun-damaged skin is more noticeable
- ○ I am noticing more fine lines and wrinkles
- ○ I have dry or thinning skin
- ○ I have no interest in sex
- ○ I have vaginal dryness or pain with intercourse

Total_____

PROGESTERONE DEFICIENCY

- ○ I experience PMS 7 to 10 days before my period
- ○ I get headaches or migraines around my period
- ○ I feel anxious often
- ○ I have painful, heavy or difficult periods
- ○ My breast are painful or swollen before my period
- ○ I have had a miscarriage in the first trimester
- ○ I experience restless legs, especially at night
- ○ I have had difficulty getting pregnant (after trying for 6 or more months)

Total_____

EXCESS TESTOSTERONE

- ○ I have abnormal hair growth on my face, chest, and/or abdomen
- ○ I have acne
- ○ I have oily skin and/or hair
- ○ I have noticed thinning hair on my head
- ○ I have skin tags
- ○ I struggle with depression and/or anxiety
- ○ I have polycystic ovarian syndrome (PCOS)
- ○ I have had difficulty getting pregnant (after trying for 6 or more months)

Total_____

LOW TESTOSTERONE

- ○ I have low libido or diminished sex drive
- ○ I struggle with depression, have mood swings, or cry easily
- ○ I have no motivation
- ○ I am tired or fatigued throughout the day or have been diagnosed with chronic fatigue syndrome
- ○ I am unable to gain muscle and I am losing muscle mass
- ○ I have a decrease in bone density or have been diagnosed with osteopenia or osteoporosis
- ○ I have urinary incontinence
- ○ I have a loss of sexual fantasies
- ○ I have difficulty or am unable to orgasm
- ○ I have cardiovascular symptoms or heart disease
- ○ I have had weight gain
- ○ I have anxiety or panic attacks

Total_____

LOW THYROID HORMONE

- ○ I have brain fog or feel like my memory isn't quite what it used to be
- ○ I am losing hair (scalp, body, outer third of eyebrow)
- ○ My hair is dry and tangles easily
- ○ I am constipated often and need caffeine to get a bowel movement
- ○ I am cold and/or have cold hands and feet
- ○ My periods are sporadic or occur more than 35 days apart
- ○ I have joint or muscle pain
- ○ I have dry skin
- ○ I have had difficulty getting pregnant (after trying for 6 or more months) or have had a miscarriage
- ○ I am in a low mood or struggle with depression
- ○ I am tired no matter how much I sleep
- ○ I find it difficult to break a sweat
- ○ I have recurrent headaches
- ○ I have high cholesterol
- ○ I have a hoarse voice most days

Total_____

Score

0-1 = this category is unlikely causing your symptoms
2-4 = this area needs your attention
5+ = this hormonal imbalance is likely causing your symptoms

Binge Eating Disorder Screener-7

The following questions ask about your eating patterns and behaviors **within the last 3 months**. For each question, choose the answer that **best** applies to you.

1. **During the last 3 months**, did you have any episodes of excessive overeating (i.e eating significantly more than what most people would eat in a similar period of time)?	yes	no

NOTE; IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP.
THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	yes	no

	never or rarely	sometimes	often	always
3. **During your episodes of excessive overeating**, how often did you feel you had no control over your eating (e.g. not being able to stop eating, feel compelled to eat, or going back and forth for more food?)				
4. **During your episodes of excessive overeating**, how often did you continue eating even though you were not hungry?				
5. **During your episodes of excessive overeating**, how often were you embarrassed by how much you ate?				
6. **During your episodes of excessive overeating**, how often did you feel disgusted with yourself or guilty afterwards?				
7. **During the last 3 months**, how often did you make yourself vomit as a means to control your weight or shape?				

Julianne Dunne, MD ⌘ westmed ✉ 3030 Westchester Avenue Suite 202 ★ Purchase, NY 10577 ☏ (914) 848-8668

Sleep Assessment

How well do you sleep at night? *Check all that may apply*
○ through the night ○ fall asleep easily but can't stay asleep ○ difficulty falling asleep ○ frequent or early morning wakening
Do you have a sleep problem that has been diagnosed? ○ yes ○ no
If yes, what?_____
If no, do you feel that you have a sleep problem? ○ yes ○ no
If yes, how would you describe it?_____
Have you ever had a **sleep study?** ○ yes ○ no
If yes, when did you have the study done?_____
○ in office study ○ home study
What were the results?_____
If you have been diagnosed with sleep apnea, do you use a **CPAP machine?** ○ yes ○ no

Sleep Apnea Assessment

Do you **snore** extremely loud so that you may be heard from another room?	○ yes ○ no
Do you often feel **tired**, fatigued or sleepy during the daytime?	○ yes ○ no
Has anyone ever **observed** that you pause in your breathing when you sleep?	○ yes ○ no
Are you treated for high blood **pressure**?	○ yes ○ no
Is your **Body Mass Index** (BMI) > 35?	○ yes ○ no ○ unsure
Are you **age** 50 or older?	○ yes ○ no
Is your **neck** circumference greater than 16 inches?	○ yes ○ no ○ unsure
Are you **male**?	○ yes ● no

The Epworth Sleepiness Scale

Use the scale below to choose the most appropriate number for each situation

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. in a theater)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

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Patient Health Questionnaire (PHQ 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. little interest or pleasure in doing things	○	○	○	○
2. feeling down, depressed, or hopeless	○	○	○	○
3. trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. feeling tired or having little energy	○	○	○	○
5. poor appetite or overeating	○	○	○	○
6. feeling bad about yourself – or that you're a failure or have let yourself or your family down	○	○	○	○
7. trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. thoughts that you would be better off dead or of hurting yourself	○	○	○	○

TOTAL

General Anxiety Disorder (GAD 7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. feeling nervous, anxious or on the edge	○	○	○	○
2. not being able to stop or control worrying	○	○	○	○
3. worrying too much about different things	○	○	○	○
4. trouble relaxing	○	○	○	○
5. being so restless that it is hard to sit still	○	○	○	○
6. becoming easily annoyed or irritable	○	○	○	○
7. feeling afraid as if something awful might happen	○	○	○	○

TOTAL

If you checked off any problems, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Are you currently being treated for depression? ○ yes ○ no
Are you currently being treated for anxiety? ○ yes ○ no
Are you taking medication for depression and/or anxiety? ○ yes ○ no
If yes, which ones? _____
Who prescribes these medications? _____

Julianne Dunne, MD ⌘ westmed ✉ 3030 Westchester Avenue Suite 202 ★ Purchase, NY 10577 ☏ (914) 848-8668

Review of Symptoms

Do you have any of the following **general symptoms?** ○ none
○ fatigue ○ difficulty sleeping ○ snoring ○ daytime sleepiness ○ forgetfulness

Do you have any of the following **visual symptoms?** ○ none
○ blurry vision ○ double vision ○ loss of vision

Do you have any of the following **ear, nose** or **throat symptoms?** ○ none
○ sore throat ○ hoarseness ○ nasal/sinus problems

Do you have any of the following **cardiovascular symptoms?** ○ none
○ chest pain ○ palpitations ○ leg swelling ○ sudden awakening from sleep with shortness of breath
○ passing out ○ varicose veins ○ hemorrhoids

Do you have any of the following **pulmonary symptoms?** ○ none
○ shortness of breath ○ wheezing ○ blood in sputum ○ sleep apnea

Do you have any of the following **gastrointestinal symptoms?** ○ none
○ gastric reflux/heartburn ○ gallstones ○ constipation ○ vomiting ○ diarrhea ○ abdominal pain
○ abdominal bloating ○ blood in stool

Do you have any of the following **urinary symptoms?** ○ none
○ loss of urine ○ frequent urination ○ urination more than 1 time overnight ○ prolapsed bladder or uterus
○ blood in urine ○ recurrent urinary tract infections

Do you have any of the following **musculoskeletal symptoms?** ○ none
○ low back pain ○ knee pain ○ joint pain/swelling ○ muscle pain/cramps ○ muscle stiffness

Do you have any of the following **skin conditions?** ○ none
○ acne ○ eczema ○ dark skin around neck or groin ○ stretch marks ○ skin tags ○ skin ulcers

Do you have any of the following **neurologic symptoms?** ○ none
○ frequent headache ○ weakness ○ carpal tunnel syndrome ○ impaired balance ○ numbness or tingling

Do you have any of the following **psychological symptoms?** ○ none
○ depression ○ stress ○ anxiety ○ poor self-image ○ social isolation

Do you have any of the following **endocrine symptoms?** ○ none
○ heat intolerance ○ cold intolerance ○ increased thirst ○ excessive sweating ○ hair loss

Do you have any of the following **allergic symptoms?** ○ none
○ hives ○ hay fever ○ food allergies or sensitivities ○ frequent infections

Do you have any of the following **gynecologic symptoms?** ○ none
○ irregular periods ○ painful periods ○ recurrent genital itch or discharge ○ premenstrual syndrome
○ low sex drive ○ painful intercourse

Do you have any of the following **reproductive issues?** ○ none
○ infertility ○ recurrent miscarriage ○ history of preterm labor or delivery ○ history of pre-eclampsia

****BELOW FOR OFFICE USE ONLY****

I have reviewed the above medical and nutritional history

	Julianne Dunne, MD/Lisa Luehman, NP	
Signature	Name	Date