## Table 5: Recommended Key Components of An Obesity-Centred Medical History

| Interview Component | Details | Implication/Significance /Recommended Actions |
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| Weight history | Document age of onset of obesity and major weight trajectories over time<br><br>Previous weight loss attempts and response to interventions (including behavioural interventions, medications, endoscopic and surgical interventions<br><br>Highest and lowest weight<br><br>Major life event(s) associated with weight change<br><br>Current phase of weight (e.g., gaining, losing, stable) | Can help to understand patients weight journey, success / failures of past attempts and causes of weight gain / loss in the past, childhood vs adult obesity<br><br>Can help to establish realistic expectations<br><br>Can help to prevent future weight gain and target behavioural and psychological treatment<br><br>Can help to make appropriate goals (ex. weight stabilization if currently gaining weight)<br><br>Key Processes[15,24]<br>• Show compassion<br>• Real listening (paraphrase and summarize to ensure you understand and validate the patient's thoughts)<br>• Help patients make sense of their story (find root causes, foster insight, find patterns/triggers, identify values/goals, reflect on timeline to acknowledge impact on life in context to weight) |
| Nutrition history | Assess nutrition literacy<br><br>Assess energy intake<br><br>Identify current nutritional restrictions (Celiac disease, allergies) | Is there concern of physiological hunger, emotional eating, mindless eating, knowledge deficit?78<br><br>See the chapter Medical Nutrition Therapy in Obesity Management for details |
| Physical activity | Current physical activity including time spent in sedentary activities<br><br>Limitations to activity (e.g., pain, time, motivation)<br><br>Identify social limiting factor restricting access to increasing physical activity | Help patient to make self-directed activity goals<br><br>Address limitations independently (ex. pain management for joint pain etc.)<br><br>See the chapter Physical Activity in Obesity Medicine<br><br>Key Processes:[15,24]<br>• Recognize strengths<br>• Shift beliefs<br>• Reframe misconceptions<br>• Help establish whole person value goals and functional outcomes instead of weight-based goals |
| Depression and anxiety screening | Screen for depression and anxiety | Consider referral to psychiatry/psychology |
| Other mental health issues/drivers | Screen for attention deficit hyperactivity disorder, post-traumatic stress disorder, chronic grief<br><br>Psychological impact of previous weight journey | Consider referral to psychiatry/psychology<br><br>Review challenges with body image, self-esteem |
| Addiction/ dependency | Smoking status<br><br>Alcohol intake<br><br>Use of cannabinoids and other psychoactive substances<br><br>Current or previous abuse of substance<br><br>Excessive use of caffeine containing beverages (e.g. sugar sweetened beverages) | Consider referral to psychiatry/psychology |

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| Abuse | Screen for previous and current forms of abuse physical, psychological and sexual. | Unresolved history of abuse and current abuse can be a barrier to obesity management and can have an impact on food behaviours and relationship with food.<br><br>Interdisciplinary approach may be required. |
| Sleep history | Number of hours of sleep per night<br><br>Use of pharmacologic sleeping aids<br><br>Sleep apnea-hypopnea screening (such as STOP BANG Sleep Apnea Questionnaire) | Poor sleep quality and quantity can be a barrier to obesity management.[79]<br><br>If positive screening (STOP BANG > 4), consider referral to rule out sleep apnea. |
| Medication history | Review medications that can have a significant impact on weight.[80] | See Table 8.<br><br>Key processes:[15,24]<br>• Make sense of the story<br>• Help establish root causes |
| Social history | Age, sex, ethnicity, marital status, occupation/work schedule: number of hours per week, night shift work | Eating behaviours in shift workers may require additional consideration when deciding therapeutic options |
| | Income support, medical coverage, access to exercise facilities | Evaluate patients' access to food options, nutritional education, cooking skills<br><br>Consider involving a social worker/counsellor in cases where income, medication coverage and resource access may be limited. |
| | Level of functional independence | In patients with decreased independence, consider involving caregivers and decision makers |
| Family history | History of first-degree relative with overweight/obesity or related complications?<br><br>Overweight and obesity in other household members | Can help determine patients' risk of obesity or related complications<br><br>Group interventions are more challenging but more likely to be feasible and sustainable in patients exposed to environments where obesity is highly prevalent |
| Interpersonal assessment | Motivation<br><br>Confidence<br><br>Readiness to change<br><br>Expectations | See the chapter Effective Psychological and Behavioural Interventions in Obesity Management<br><br>Key Processes:[15,24]<br>• Recognize strengths<br>• Shift beliefs (help manage expectations, focus on the whole health of the patient)<br>• Co-construct a new story (context integration, prioritizing goals)<br>• Orient values and plan actions (help establish direction)<br>• Foster reflection (insight, motivation, accountability)<br>• Help internalize core messages (help establish coping skills) |