WEIGHT MANAGEMENT MEDICINE
PATIENT HISTORY QUESTIONNAIRE

*The information requested below is very important. To give you the best care, we must have complete and **honest** answers. Please be thorough and print clearly with black ink. Thank you.*

Patient Name: _____ Date of Birth: _____

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Events	Age	Weight
Child obesity		
High School Graduation		
College years		
Marriage		
Lowest weight in past 5 years		
Highest weight in past 5 years		
Weight one year ago		
Other:		
Other:		
Other:		

What is your Goal Weight? _____
Do you use a home scale? ☐Yes ☐No How often do you weight yourself? _____
Have you had bariatric surgery? ☐Yes ☐No
If No, are you interested in learning more about bariatric/weight loss surgery? ☐Yes ☐No
If Yes, which procedure and when: ☐LapBand ☐Gastric ByPass ☐Gastric Sleeve Date: _____

What is motivating you to seek this type of intervention for weight control and/or loss?

_____

SOCIAL HISTORY:

1. Do you use any tobacco? ☐Yes ☐No Do you vape? ☐Yes ☐No
   a. If yes – what? _____
   b. How often/much? _____
2. Do you drink alcohol? ☐Yes ☐No
   a. If yes – what kind/how much/often? _____
3. Any drug use? ☐Yes ☐No
   a. If yes – type/how much/often? _____
4. History of drug overdose? ☐Yes ☐No
   a. If yes – when? _____

FAMILY HISTORY:

Is there Obesity in the family? ☐Yes ☐No If yes, please list: _____

_____

Are there any medical illnesses in your immediate family? ☐Yes ☐No If yes, what/who:

Diabetes? ☐Yes ☐No Who: _____

Hypertension? ☐Yes ☐No Who: _____

Coronary Artery Disease? ☐Yes ☐No Who: _____

Cancer? ☐Yes ☐No Type: _____ Who: _____

Other: _____ _____

WEIGHT LOSS ATTEMPT HISTORY:

Please list ALL weight loss attempts, physician-supervised programs as well as self-monitored diets. Please take the time to be as thorough as possible.

Age you first started dieting: _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ACUPUNCTURE						☐Yes ☐No
JENNY CRAIG						☐Yes ☐No
ATKINS						☐Yes ☐No
KETO-DIET						☐Yes ☐No
Calorie Counting						☐Yes ☐No
RICHARD SIMMONS						☐Yes ☐No
WEIGHT WATCHERS						☐Yes ☐No
SOUTH BEACH						☐Yes ☐No
ALLI						☐Yes ☐No
NUTRI-SYSTEMS						☐Yes ☐No
OPTI-FAST or MEDI FAST						☐Yes ☐No
OVER THE COUNTER List Names:						☐Yes ☐No
PHENTERMINE						☐Yes ☐No
MERIDIA						☐Yes ☐No
METABOLIFE						☐Yes ☐No
XENICAL						☐Yes ☐No
OTHER:						☐Yes ☐No
Any Rx med for weight loss? Rx Name(s):						☐Yes ☐No
Other Prescription/Shots						☐Yes ☐No
Other bariatric program? Which Surgeon?						☐Yes ☐No
Any support groups?						☐Yes ☐No

List any other physician-supervised and documented weight loss attempt:

_____

_____

FOOD INTAKE:

What specific Food Plan/Diet are you currently following, if any? _____

How many meals do you consume per day? _____

Do you skip meals? ☐Yes ☐No Number of snacks per day? _____

Do you eat breakfast? ☐Yes ☐No

How late is your dinner? _____ When is your typical bedtime? ____ Do you snack after dinner? ___

Do you snack between meals? ☐Yes ☐No

If so, what? _____

How often? _____

Is snacking from habit? ☐Yes ☐No Depression? ☐Yes ☐No

Boredom? ☐Yes ☐No Do you binge eat? ☐Yes ☐No

If so, what? _____

How often? _____

Do you have any eating related problems or concerns? ☐Yes ☐No If yes, please explain: _____

_____

Are you willing to cook or prefer purchasing meals? _____

Do you feel deprived of any foods? ☐Yes ☐No

Do you feel restricted of any foods? ☐Yes ☐No

Any foods/beverages not tolerated? ☐Yes ☐No If so: _____

_____

Do you have any diet restrictions?

Vegan? ☐Yes ☐No

Vegetarian? ☐Yes ☐No

Lactose intolerant? ☐Yes ☐No

Gluten Free? ☐Yes ☐No

Other? _____

How many grams of protein do you get in daily? (best estimate) From drinks? _____

From food? _____

How much **WATER** do you drink in a 24-hour period? ☐24oz (3 cups or less) ☐32oz (4+ cups) ☐64oz (8+ cups) Other: _____

What do you drink other than water? _____ How much? _____

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	***Place***	***Food/beverage***	***Amount***
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

PHYSICAL ACTIVITY:
Do you exercise regularly? ☐Yes ☐No If yes, do you have an exercise regimen? Please list in table below.
Do you have any physical restrictions that keep you from exercising? If Yes, Explain? _____

Type of Physical Activity (Walking, Yoga, Cardio, Weights, Swim, etc)	Intensity (Light, medium or high)	Daily?	How often?	Comments
		☐Yes ☐No		
		☐Yes ☐No		

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following? Check all that apply.

Psychologic

1. Do you have any of the following? (Please check all that apply)
   a. ☐Depression ☐Panic attacks ☐Anxiety ☐Bipolar Disease ☐Obsessive Compulsive Disorder ☐Eating Disorder ☐other: _____
   b. Seeking treatment? ☐Yes ☐No
   c. Medications? ☐Yes ☐No Please list under medications
2. Do you have a history of suicide attempt or suicidal ideation? ☐Yes ☐No
   If so, when: _____
3. Are you currently seeing a psychologist/psychiatrist/therapist? ☐Yes ☐No.

Sleep Health

1. How many hours do you typically sleep per night? _____ hours
2. If you have insomnia, do you have trouble falling asleep or staying asleep? ☐Yes ☐No
3. Have you been told you stop breathing when sleeping? ☐Yes ☐No
4. Do you have excessive daytime sleepiness? ☐Yes ☐No
5. Have you been diagnosed with Sleep Apnea? ☐Yes ☐No
6. If yes, do you use a CPAP or oral device? ☐Yes ☐No

Cardiovascular

1. High blood pressure ☐Yes ☐No
2. If yes – medication? ☐Yes ☐No Please list under medications
3. Heart Attack? ☐Yes ☐No When? _____
4. Heart Bypass surgery? ☐Yes ☐No When? _____
5. Stents? ☐Yes ☐No When? _____
6. Pacemaker? ☐Yes ☐No When? _____

Endocrine

1. Diabetes? ☐Yes ☐No
2. If Yes, do you have Low Sugar Episodes?
3. If Yes, please write your current A1C blood test value if known? _____
4. If Yes – medication? ☐Yes ☐No Please list under medications
5. Thyroid problems? ☐Yes ☐No
6. Medications? ☐Yes ☐No Please list under medications

Gastrointestinal

1. Heartburn? ☐Yes ☐No
   If yes – how often a week? _____
2. Medications? ☐Yes ☐No Please list under medications
3. Do you get pain in your upper abdomen after eating or in the middle of the night other than heartburn? ☐Yes ☐No
4. Have you ever been told you have gallstones? ☐Yes ☐No
5. Have you ever been told you have a fatty liver? ☐Yes ☐No

Respiratory

1. Do you have asthma? ☐Yes ☐No
2. Do you have COPD/Emphysema?
   If yes – medications? ☐Yes ☐No Please list under medications
3. How far can you walk before you get short of breath? _____

Musculoskeletal

1. Do you have joint pain? ☐Yes ☐No
2. If yes – where? _____
3. Do you take medication for this? ☐Yes ☐No
   Please list under medications
4. Have you see an Orthopedic MD or this? ☐Yes ☐No
5. Have you had surgery for this? ☐Yes ☐No
   a. If yes – when and what? _____
6. Are you waiting for a joint replacement until you lose weight? ☐Yes ☐No

Any other medical history/conditions besides listed above?

_____

_____

_____

Medications (Including Vitamins): ☐ I currently do not take any medication

Medication	Dosage	Frequency	Comments

Please attach medication list if applicable

Thank you for taking the time to answer all the questions.

I certify that all the information that I provided on this questionnaire is true, accurate, and complete.