Medical Weight Management Clinics

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Patient Questionnaire

Name	Date of Birth	Today's Date
Mailing Address		
E-mail Address	Home Phone	Work Phone

Please complete the following (strictly confidential):

1. When did you begin to gain weight?
   - ❑ After childbirth ❑ After marriage
   - ❑ After an employment change
   - ❑ During a stressful period
   - ❑ Other
2. How long have you been overweight?
   - ❑ I year or less ❑ 2-5 years
   - ❑ 6-10 years ❑ 10 years
3. What do you feel is the reason for your weight problem?
   - ❑ Frequently overeat
   - ❑ Enjoy fattening foods
   - ❑ Lack of activity
   - ❑ Heredity
   - ❑ Other _____
4. How many meals do you eat daily? _____
5. How many serious attempts have you made at dieting? _____
6. How long have you been able to stick to a diet?
   - ❑ 0-1 month ❑ 2-6 months
   - ❑ 7-12 months ❑ Over 12 months
7. What other weight reduction methods have you tried?
   - ❑ Weight Watchers ❑ Other diet centers
   - ❑ Diet books ❑ Physicians
   - ❑ Do it yourself
8. Why have you dropped out of diets before?
   - ❑ Boredom ❑ Hunger
   - ❑ Stress ❑ Need assistance
   - ❑ Other _____
9. What is the nature of your difficulties while dieting? _____
   _____
10. Are you under a physicians care?
    - ❑ Yes ❑ No
11. Have you been advised by your physician to lose weight?
    - ❑ Yes ❑ No
12. Do you have any physical problems that you know are associated with your weight?
    - ❑ Yes ❑ No
13. Why do you want to lose weight?
    - ❑ Promotes social activity
      - ❑ Appearance
      - ❑ Special Occasion _____
      - ❑ Health reasons
      - ❑ To please family/friends
      - ❑ Other _____ _
14. Has your husband or wife encouraged you to lose weight? ❑ Yes ❑ No
15. How important is it to you to lose weight?
    - ❑ Extremely Important
    - ❑ Very important
    - ❑ Important
    - ❑ Not very important
16. Do you work outside the home?
    - ❑ Yes ❑ No
    - ❑ Full-time ❑ Part-time

    Occupation _____ _
17. Sex
    - ❑ Male ❑ Female
18. Age
    - ❑ Under 18 ❑ 18-24 ❑ 25-34
    - ❑ 35-49 ❑ 50-64 ❑ Over 64
19. Marital Status
    - ❑ Married ❑ Divorced ❑ Single
    - ❑ Widowed ❑ Living with partner
20. Number of Children __ Ages: _____ _
21. Are any of your children overweight?
    - ❑ Yes ❑ No
22. What is your current weight? _____ lbs.
23. What was your highest weight in the last 5 years? _____ lbs.
24. What was your lowest weight in the last 5 years? _____ lbs.
25. What is your goal weight? _____ lbs.

Client Medical Summary

The following information is necessary for our staff to determine your eligibility for the program and to establish your needs during the weight loss period. Please answer all questions accurately to the best of your knowledge.

PERSONAL INFORMATION

Name _____Phone _____

Address _____

City _____ State ____ Zip_____

Age _____ Occupation _____

Employed by _____

Referred by _____

Spouse _____

HEALTH HISTORY

Personal Physician _____

Date last physical exam _____

Medication now taking _____

Known allergies _____

Are you now under a physician's care for any acute or chronic medical condition requiring regular treatment? ❑ Yes ❑No

Describe briefly _____

Have you ever received treatment for any of the following?

Yes	No		Yes	No	
❑	❑	cancer	❑	❑	arthritis
❑	❑	liver disease	❑	❑	ulcers
❑	❑	pancreatic disease	❑	❑	osteoporosis
❑	❑	hepatitis	❑	❑	colitis
❑	❑	kidney disease	❑	❑	hypoglycemia
❑	❑	bladder infection	❑	❑	diabetes
❑	❑	gout	❑	❑	chest pain
❑	❑	high blood pressure	❑	❑	stroke
❑	❑	heart attack	❑	❑	enteritis
❑	❑	diverticulitis			

Do you have a colostomy? ❑ Yes ❑ No

Have you had intestinal bypass surgery? ❑ Yes ❑ No

Are you now pregnant or breast feeding? ❑ Yes ❑ No

Comments _____

_____

_____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING:

Yes	No		Yes	No	
❑	❑	diabetes	❑	❑	much sweating
❑	❑	heart trouble	❑	❑	frequent colds
❑	❑	gall bladder trouble	❑	❑	bladder trouble
❑	❑	kidney trouble	❑	❑	painful urination
❑	❑	stomach ulcers	❑	❑	asthma
❑	❑	cancer	❑	❑	poor digestion
❑	❑	tuberculosis	❑	❑	bloating
❑	❑	loss of hair	❑	❑	stomach burning
❑	❑	bleeding gums	❑	❑	poor bowel action
❑	❑	sore mouth	❑	❑	loose bowel action
❑	❑	sinus trouble	❑	❑	rectal pain
❑	❑	itchy skin	❑	❑	fast pulse
❑	❑	skin rash	❑	❑	palpitation
❑	❑	allergies	❑	❑	irregular heart
❑	❑	arthritis	❑	❑	lung trouble
❑	❑	leg cramps	❑	❑	difficulty sleeping
❑	❑	swollen hands	❑	❑	severe nervousness
❑	❑	dry skin	❑	❑	oily skin
❑	❑	brittle fingernails	❑	❑	headache
❑	❑	dizziness	❑	❑	fainting spells
❑	❑	tiredness	❑	❑	chest pains
❑	❑	back ache			

ARE YOU NOW TAKING:

Yes	No	
❑	❑	drugs
❑	❑	hormones
❑	❑	stomach medicine
❑	❑	laxatives
❑	❑	heart medicine

HAVE YOU EVER TAKEN:

Yes	No	
❑	❑	thyroid
❑	❑	insulin
❑	❑	cortisone
❑	❑	birth control pills

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