WEIGHT, HEALTH, AND LIFESTYLE QUESTIONNAIRE

All questions contained in this questionnaire are confidential and will become part of your medical record. All questions are optional.

Today's Date: _____

Name: (First)_____(MI)_____(Last) _____

Date of Birth:_____/_____/_____

Ethnicity (*Check all that apply*): □ American Indian □ Asian □ African American □ Hispanic □ White □ Other: _____

Referred By: _____

WEIGHT HISTORY

1. At what age did weight first become a problem for you?
   □ Childhood □ Teens □ Adulthood □ Pregnancy □ Menopause
2. Have there been any circumstances or life events that have triggered weight gain for you?
   □ Pregnancy □ Job change □ New medication □ Stress □ Boredom
   □ Marriage □ Divorce □ Illness □ Injury □ Abuse
   □ Alcohol □ Nightshift work □ Travel □ Quitting smoking
   □ New medication: _____ □ Other _____
3. What was your weight one year ago?_____lbs Two years ago?_____lbs Five years ago?_____lbs
4. What has been your highest weight? _____lbs
5. What was your weight around age 20? _____lbs
6. During the past 6 months my weight has: □ increased by ____lbs □ decreased by ____lbs □ been relatively the same
7. Have you lost weight with weight loss programs or diet plans in the past? If so, select from the list the program/method. (*check all that apply*):
   □ Weight Watchers □ Nutrisystem □ Jenny Craig □ LA Weight Loss
   □ Atkins □ Keto diet □ South Beach □ Zone diet
   □ Medifast □ Dash diet □ Paleo diet □ Mediterranean diet
   □ Ornish diet □ Intermittent Fasting □ Time restricted eating
   □ Other: _____
8. Have you ever used any prescription medications for weight loss? (*check all that apply*):
   □ Phentermine (Adipex) □ Meridia □ Xenecal/Alli □ Phen/Fen
   □ Phendimetrazine (Bontril) □ Topamax □ Saxenda □ Diethylpropion
   □ Bupropion (Wellbutrin) □ Belviq □ Qsymia □ Contrave
   □ Wegovy □ Other (including supplements):_____

   If so, how much weight did you lose with the medication, and did you experience any side effects?

   _____
9. Have you ever had bariatric surgery? □ Yes □ No
   a. If yes, please list the procedure(s) and year(s). _____
   b. Are you currently interested in considering bariatric surgery? □ Yes □ No
   c. Have you ever consulted a surgeon regarding bariatric surgery? □ Yes □ No

10. What do you consider some of your barriers when it comes to managing your weight? (*check all that apply*)

□ Hunger □ Cravings □ Fatigue □ Finances
□ Time □ Knowledge □ Other _____

11. How is your weight affecting your health and your life? _____

_____

12. How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which 1 = not motivated and 10 = greatest motivation you've ever had. Your number is _____.

13. Why do you want to lose weight right now, as compared to 1 year ago? What has prompted you to lose weight now? _____

_____

14. What are your goals/anticipated outcomes from this program? _____

_____

_____

15. What is the **single most important thing** that you hope to achieve as a result of losing weight?

_____

_____

16. People who want to achieve long-term weight control need to spend at least 30 minutes a day, for a minimum of 6 months trying to change their eating, exercise, and thinking habits.

Please check the number below that best describes you:

□ 1. I definitely will not be able to devote 30 minutes daily to weight control.
□ 2. I'm not sure if I can find 30 minutes daily for weight control.
□ 3. I think I can probably find 30 minutes daily for weight control.
□ 4. I can definitely find 30 minutes daily for weight control.
□ 5. I can devote more than 30 minutes daily to weight control

17. Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10, in which 1 = not at all confident and 10 = extremely confident. Your number is _____.

NUTRITION

1. How do you feel about your current eating habits?

□ Could be better □ Pretty good overall but room for improvement □ I have great habits

2. Are you currently following a particular eating plan? □ Yes □ No. If yes, which one?

□ Low fat □ Low carb □ Keto □ Mediterranean
□ Vegetarian/Vegan □ Intermittent fasting □ Other _____

3. Number of meals and snacks you eat on an average day:

□ 3 □ 3-5 □ 6-8 □ 8-10+

4. Food allergies / intolerances (*check all that apply*):

□ Gluten □ Dairy □ Tree nuts □ Eggs □ Soy □ Fish / Shellfish
□ Other: _____

5. Who does the most of the cooking and/or grocery shopping at your house?

□ Self □ Spouse/Partner □ Other member of household □ Other

6. Food preferences including ethical or cultural considerations: _____

_____

7. During a typical week, how many meals do you eat at a fast-food restaurant (including drive-thru and convenience stores)?

Breakfast ____ meals a week Lunch ____ meals a week Dinner ____ meals a week

8. During a typical week, how many meals do you eat at or get take-out from traditional restaurant, coffee shop, cafeteria, or similar establishment?

Breakfast ____ meals a week Lunch ____ meals a week Dinner ____ meals a week

9. How much water do you drink per day on average? _____ ounces

10. Do you drink caloric beverages such as soda, juice, sweetened tea, or coffee with creamer or sugar?

□ Yes □ No. If yes, what kind(s)?_____

How many ounces per day on average?_____

11. Do you drink alcohol? □ Yes □ No. If yes, what kind? (*check all that apply*)

□ Beer □ Wine □ Liquor □ Cocktails

12. How many alcoholic drinks per week do you drink per week?

□ None □ 1-3 drinks □ 4-7 drinks □ more than 8 drinks

13. Are you frequently hungry? □ Yes □ No

14. Do you feel full after meals? □ Yes □ No

15. How soon after the last meal do you feel hungry? _____

16. Do you have cravings for certain types of foods (sweet, savory, salty, crunchy)? □Yes □No

17. How well are your cravings controlled? □ poorly controlled □ moderately controlled □ well controlled

18. Triggers for eating (*check all that apply*:)

□ Hunger □ Stress □ Boredom □ Cravings □ Emotions

□ Time of day □ Socializing □ Eating out □ Seeking reward □ Insomnia

□ Other _____

19. Barriers to eating healthy (*check all that apply*):

□ Cooking skills □ Financial reasons □ Access to healthy foods □ Time

□ Schedule □ Home circumstances □ Work circumstances □ Other _____

NUTRITION HISTORY

Please list your food and beverage intake for the past 24 hours.

TIME	FOOD & BEVERAGES CONSUMED	PLACE CONSUMED

EATING PATTERNS

1. What is your usual eating pattern?
   - □ Varies from day-to-day
   - □ Varies/week vs weekend
   - □ Grazer
   - □ No pattern/random
   - □ Night-time eating
   - □ 3 meals per day
   - □ Skip meals
   - □ 3 meals plus snacks
2. During the past 3 months, did you have any episodes of eating unusually large amount of food within a 2-hour period? □ Yes □ No

   IF NO, SKIP TO QUESTION 3 in this section

   A. If yes, during the times when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating? □ Yes □ No

   B. On average, how many days has this occurred in the past 3 months?
   □ Less than 1 day/week □ 1 day/week □ 2-3 days/week □ 4-5 days/week □ nearly every day

   C. Did you usually have the following experience during these occasions? (Check all that apply)
   - □ Eating more rapidly than usual
   - □ Eating until you felt uncomfortably full
   - □ Eating large amounts of food when you didn't feel physically hungry
   - □ Eating alone because you were embarrassed by how much you were eating
   - □ Feeling disgusted, depressed, or very guilty after overeating

   D. Would other people objectively consider this an unusually large amount of food? □ Yes □ No

3. During the past 3 months…
   A. Have you made yourself vomit as a means to control your weight? □ Yes □ No
   B. Have you taken more than twice the recommended dose of laxatives or diuretics (water pills) in order to lose or avoid gaining weight? □ Yes □ No
   C. Have you exercised for more than one hour specifically in order to avoid gaining weight after binge eating? □ Yes □ No
   D. Have you taken more than twice the recommended dosage of a diet pill in order to lose or avoid gaining weight? □ Yes □ No
   E. Have you fasted (not eating anything at all for at least 24 hours) in order to avoid gaining weight after binge eating? □ Yes □ No
4. Current or past history of an eating disorder? □ Yes □ No.

   If yes, please elaborate: _____

PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity?

   □ not at all □ slightly □ moderately □ greatly
2. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class?

   □ Never □ 1-2x/ week □ 3-4x/ week □ 5 or more x/week
3. How many minutes does each bout of exercise typically last?

   □ 10 min or less □ 10 min - 20 min □ 20 min - 30 min □ more than 30 min
4. Type of activities you participate in regularly (*check all that apply*)

   □ Walking □ Biking □ Strength training □ Yoga

   □ Other _____
5. List any barriers to physical activity. (Time, joint pain, motivation, etc.) _____

   _____
6. List equipment / spaces available to you for activity.

   □ Gym membership □ stationary bike □ free weights □ walking path

   □ Other _____
7. What types of activities do you enjoy or have enjoyed in the past? _____

   _____
8. How many hours per day on average do you spend in front of a screen (TV, phone, computer, tablet)?

   _____hours during work. _____ hours before/after work. _____ hours on days off work.
9. Please describe your daily lifestyle activity (how active you are) by picking a number from 1 to 10, in which 1 = very sedentary and 10 = very active. Your number is ____.

SLEEP

1. How many hours of sleep do you average per night?

   □ Less than 5 hours □ 5-7 hours □ 7-9 hours □ more than 9 hours
2. Do you work a night shift or shift work? □ Yes □ No
3. Usual bedtime:_____Usual waking time: _____
4. Do you have trouble falling asleep or staying asleep? □ Yes □ No

5. Do you feel rested after sleeping? □ Yes □ No
6. Are you tired throughout the day? □ Yes □ No
7. Do you snore? □ Yes □ No
8. Has anyone observed that you stop breathing during sleep? □ Yes □ No
9. Do you often wake up with headaches in the morning? □ Yes □ No
10. Do you take naps during the day? □ Yes □ No
11. Have you ever been evaluated for sleep apnea or other sleep related disorders? □ Yes □ No.

    If yes, were you diagnosed with sleep apnea? □ Yes □ No

    If yes, do you use a CPAP, BiPap or other device? _____
12. What prevents you from getting good sleep? _____

OCCUPATION AND HOME LIFE

1. How many people live with you in your home? _____
2. If there are children in your home, please indicate their ages: _____
3. What is your occupation? _____
4. Highest level of education completed?

   □ Grammar School □ High School □ College □ Graduate School Are you in school now?_____
5. Do you have good social support for healthy lifestyle changes? □ Yes □ No

   If so, list your "support people":_____

   _____
6. If you are currently involved in an intimate relationship (significant other)
   a. What is this person's attitude towards your efforts to lose weight? _____
   b. Please briefly describe what this person does either to help or hinder your efforts to lose weight.

   _____

   _____

MENTAL HEALTH

1. Is stress a major problem for you? □ Yes □ No

   Rate your stress level on a scale from 1 to 10: _____
2. Do you feel like you have healthy coping mechanisms for stress? □ Yes □ No

   How do you cope with your stress? _____
3. Do you consider yourself an "emotional eater"? □ Yes □ No
4. Do you ever feel depressed? □ Yes □ No
5. Have you ever been diagnosed with a mental health condition? □ Yes □ No

   If yes, which mental health condition? □ Anxiety □ Depression □ Bipolar disorder

   Other _____
6. Have you ever seriously thought about hurting yourself? □ Yes □ No
7. Have you ever attempted suicide? □ Yes □ No
8. Have you ever been to a counselor or other mental health professional? □ Yes □ No

   If yes, are you currently receiving counseling? _____

ALCOHOL / TOBACCO

1. Alcohol usage: □ None □ Occasional □ Regularly (___ drinks/day)

   If yes, are you concerned about the amount you drink? □ Yes □ No

   Have you had prior treatment for alcoholism? □ Yes □ No

2. Smoking / E-cigarettes usage: □ Never □ Current smoker □ Former smoker

   2a. If you are a current or past smoker, how many packs/day? _____ For how many years? _____

3. Drug usage: □ None □ Current □ Past Type of drugs: _____

4. Marijuana: □ Never □ Current user (____ times/day)

FAMILY HISTORY

Obesity (*check all that apply*) □ Mother □ Father □ Sister □ Brother
□ Daughter □ Son

Diabetes (*check all that apply*) □ Mother □ Father □ Sister □ Brother
□ Daughter □ Son

Other (*check all that apply*)

□ High blood pressure □ Heart disease □ High cholesterol
□ Stroke □ Thyroid problems □ Anxiety □ Depression
□ Bipolar disorder □ Alcoholism □ Cancer □ Other _____

MEDICATION LIST

List all the medications you currently take (*including vitamins and supplements*). Please indicate the dosage and frequency (number of times per day) of each medication.

Medication	Dosage	Frequency	Reason for taking

REVIEW OF SYSTEMS

Check all that apply

General
- ☐ Recent weight gain more than 10 lbs
- ☐ Recent weight loss more than 10 lbs
- ☐ Fever
- ☐ Fatigue
- ☐ Daytime sleepiness
- ☐ Chronic pain

HEENT
- ☐ Blurry vision
- ☐ Double vision
- ☐ Hoarse voice
- ☐ Snoring

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive sweating
- ☐ Frequent urination

Cardiovascular/Respiratory
- ☐ Chest pain
- ☐ Palpitations
- ☐ Abnormal heart rhythm
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Blood Clots
- ☐ Fainting/blacking out

Gastrointestinal
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Difficulty swallowing
- ☐ Bowel irregularity
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Blood in stools

Genitourinary
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Infertility
- ☐ Sexual difficulties
- ☐ Nighttime urination

Extremities
- ☐ Joint pain
- ☐ Muscle aches/pain
- ☐ Back pain
- ☐ Mobility issues
- ☐ Swelling in legs/ankles
- ☐ Gout

Neurologic
- ☐ Headaches
- ☐ Balance issues
- ☐ Coordination issues
- ☐ Dizziness
- ☐ Numbness
- ☐ Local weakness
- ☐ Seizures
- ☐ Memory loss

Psychiatric
- ☐ Anxious/nervous
- ☐ Depressed mood
- ☐ High stress level
- ☐ Sleep problems
- ☐ Insomnia
- ☐ Suicidal thoughts
- ☐ Mood changes
- ☐ Loss of interest

Skin
- ☐ Hair loss
- ☐ Acne
- ☐ Skin tags
- ☐ Striae (stretch marks)
- ☐ Excess skin
- ☐ Intertrigo (inflammation between skin folds)
- ☐ Skin rash

WOMEN ONLY

1. Age at onset of menstruation: _____
2. Date of last menstruation: _____
3. Do you have any of the following: heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No
4. Number of pregnancies _____. Number of live births _____.
5. Age of first pregnancy _____. Age of last pregnancy _____.
6. Pregnancy impact on weight:

	1st pregnancy	2nd preg.	3rd preg.	4th preg.
a. What was your weight at the start of your pregnancy?	_____lbs	_____lbs	_____lbs	_____lbs
b. What was your weight at delivery?	_____lbs	_____lbs	_____lbs	_____lbs
c. What was your lowest weight after delivery?	_____lbs	_____lbs	_____lbs	_____lbs

7. Did you have any pregnancy complications (gestational diabetes, preeclampsia, etc)? ☐ Yes ☐ No
   If yes, please list: _____
8. Are you currently pregnant or breastfeeding? ☐ Yes ☐ No
9. Are you planning a pregnancy within the next year? ☐ Yes ☐ No
10. Are you currently using a form of birth control? ☐ Yes ☐ No type?_____
11. Do you have any problems with urinary or bladder control? ☐ Yes ☐ No
12. Have you ever been diagnosed with PCOS? ☐ Yes ☐ No
13. Have you been affected by infertility? ☐ Yes ☐ No

MEN ONLY

1. Do you usually get up to urinate during the night? □ Yes □ No
   If yes, number of times: _____
2. Have you ever been diagnosed with erectile dysfunction? □ Yes □ No
3. Have you ever been diagnosed with low testosterone? □ Yes □ No

MEDICAL HISTORY

Have you ever been diagnosed with any of the following? (*please check all that apply*)

□ Hypertension (high blood pressure)	□ Thyroid disease	□ Chronic Kidney disease
□ Hyperlipidemia (high cholesterol)	□ Osteoarthritis	□ Autoimmune disorder
□ Diabetes (high blood sugar)	□ Back Pain	□ Pseudotumor cerebri
□ Prediabetes/ Insulin Resistance	□ Acid Reflux	□ Cushing's syndrome
□ Gestational Diabetes	□ Irritable Bowel syndrome	□ Cancer: _____
□ Infertility	□ Hernia	□ COPD/Emphysema
□ PCOS (Polycystic Ovarian Syndrome)	□ Gallstones	□ Asthma
□ Metabolic syndrome	□ Depression	□ Lymphedema
□ Fatty Liver disease	□ Anxiety	□ Sleep disorder
□ Cirrhosis	□ Bipolar disorder	□ Sleep Apnea
□ Lymphedema	□ Eating disorder: _____	□ Anemia
□ Lipidema	□ Vitamin deficiency (*please specify*): _____	
□ Heart attack	□ Coronary artery disease	□ Abnormal heart rhythm
□ Heart murmur	□ Stroke	□ Heart valve disease
□ Heart failure	□ Seizures	□ Glaucoma
□ Pacemaker implanted	□ Pancreatitis	
□ Primary Pulmonary Hypertension	□ Medullar Thyroid Cancer	□ MEN Type 2
□ Kidney Stones	□ Hyperthyroidism	

□ Other Medical Conditions: _____

SURGICAL HISTORY

Please list surgery type and year:

_____

_____

MEDICATION ALLERGIES

Please list any medication allergies and your response:

_____

_____

ADDITIONAL INFORMATION

Please use this space to provide any additional information that you think is important to understanding you or your weight problem, as well as the goals you seek.

_____

_____

_____

_____

_____