Central Family Care & Weight Loss Clinic

Medical Program Diet History and Lifestyle Questionnaire

CONFIDENTIAL **Date: _____**

NOTE: This form must be completed before you can be enrolled in the Medical Weight Management Program. Please answer every question. Please print, type or write clearly.

Name _____

Address _____

Daytime Phone No._____ E-mail_____

Occupation _____

Name of Employer _____

Birth date (Month-Day-Year) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Sex: ☐ Male ☐ Female

Weight History

Present weight (lbs) _____

Indicate ages during which you were overweight:

☐ Childhood (Age 2-11 yrs) ☐ Age 20-29 yrs ☐ Adolescence (Age 12-19 yrs) ☐ Age 30-40 yrs ☐ Over 40 yrs

Present height (feet, inches) _____

What is your goal weight? _____

When did you last weight this amount? _____

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.):

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment?
Sample: Weight Watchers	*2 months*	*Desired other foods*	*Dizziness*

Which weight loss method do you consider your most successful? _____
What accounted for that success? _____

_____

Medical History

Physician to receive your progress reports:

Name: _____ Office Address:_____Phone:

When was your most recent complete physical exam? Month:_____ Year: _____

Current medications:

Name	**Dosage**

Please check any health condition you have:

☐ Peptic ulcer disease that is not resolved or under good medical control
☐ Heart attack within last 3 months
☐ Recent onset of inflammatory bowel disease
☐ Insulin-dependent diabetes (juvenile-onset diabetes)
☐ Non-insulin dependent diabetes
☐ Liver disease requiring protein restriction
☐ Pregnant or planning to become pregnant within 6 months
☐ Kidney disease requiring protein restriction
☐ Recent treatment for cancer (please describe)_____
☐ Recent uric acid kidney stone or untreated hyperuricemia
☐ Date of most recent menstrual period_____ Number of pregnancies _____
Weight gain with pregnancies_____lbs

List other health problems:

_____
_____
_____ _____

Psychosocial History

Are you at present undergoing any major lifestyle changes (eg, marriage, divorce, job change, death of someone important to you)? If so, describe: _____

What other commitments do you that might interfere with your fully participating in the weight loss program? _____

_____

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)? ☐ Yes ☐ No

If yes, how often did you do this during the past year? (check one)

☐ Less than once a month ☐ About once a week ☐ About once a month ☐ About three times a week

☐ A few times a month ☐ Daily

Have you ever purged (used self-induced vomiting, laxatives, or diuretics)? ☐ Yes ☐ No

Lifestyle and Eating Habits

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? ☐1 drink a month ☐ 1 drink a week ☐ More than 1 drink a week ☐ 1 drink a day

☐ More than 1 drink a day _____

How often do you exercise? ☐ Rarely ☐ Occasionally ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? ☐ Yes ☐ No

Do you know of any reason why you should not exercise? ☐ Yes ☐ No

If you answered yes to either question, please explain: _____

_____

How many meals do you typically eat out per week? _____

Are the majority of these meals with family or friends? ☐ Yes ☐ No

Are they usually fast food (eg, McDonald's)? ☐ Yes ☐ No

Usually in cafeteria/restaurant? ☐ Yes ☐ No

Of the following, check all the items that you feel help explain or describe your eating habits:

☐ Thinking about food too much of the time ☐ Eating to take my mind off other problems

☐ Eating high-fat foods ☐ Not paying attention to what I'm eating

☐ Eating too many sweet foods ☐ Overeating at social events

☐ Eating too quickly ☐ Lack of satisfaction in life

☐ Uncontrollable binges ☐ Eating in reaction to boredom

☐ Eating in reaction to tension and depression ☐ Overeating when alone

☐ Using food as a reward

☐ Other (explain) _____

_____

Are you allergic to:

Cocoa? ☐ Yes ☐ No

Milk protein? ☐ Yes ☐ No

Corn? ☐ Yes ☐ No

Soy? ☐ Yes ☐ No

Eggs? ☐ Yes ☐ No

Other food? (describe) _____

_____

Are you sensitive to or do you have a problem with:

Aspartame (Nutrasweet)? ☐ Yes ☐ No

Monosodium glutamate (MSG)? ☐ Yes ☐ No

Lactose? (unable to drink milk but able to eat cheese and yogurt) ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

I certify that the information on this form is true and correct to the best of my knowledge.

Signature_____ Date _____