Trial Version Wondershare PDFelement

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*

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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:

____

____

____ ______________________

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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) ____________________

____

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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 __________