PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Medical History
Do you have any of the following medical conditions: (Currently or in the past)

Cardiovascular
- ☐ Coronary Artery Disease/Angina
- ☐ Heart Rhythm Abnormalities/A-Fib
- ☐ Heart Valve Disease
- ☐ Hypertension
- ☐ Vascular Disease

Neurologic
- ☐ Seizures
- ☐ Stroke or TIA
- ☐ Migraines

Metabolic
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ High Triglycerides
- ☐ Metabolic Syndrome
- ☐ Osteoporosis

Respiratory
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ COPD

Gastrointestinal
- ☐ Gastroesophageal Reflux
- ☐ Peptic Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)
- ☐ Lactose Intolerance
- ☐ Hepatitis
- ☐ Liver Disease (Cirrhosis or Fatty Liver)

Genitourinary
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Stress Incontinence

Reproductive
- ☐ Infertility
- ☐ Abnormal Menses
- ☐ Polycystic Ovary Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Back
- ☐ Hips
- ☐ Knees
- ☐ Gout
- ☐ Herniated Disc

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Post Traumatic Stress Disorder
- ☐ Other _____

Blood/Immune System
- ☐ Anemia
- ☐ Lupus
- ☐ Bleeding Disorders
- ☐ Clotting Disorder
- ☐ Immune Disorders
- ☐ Cancer
  Type _____

Specialists
Please list the name and specialty of any other physicians you follow with

Name:	Specialty:
1. _____	_____
2. _____	_____
3. _____	_____

Surgical History
List all surgeries you have had :

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Prescription Medications:

Name of Medication	Dosage Strength	How often med is taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Over-the-counter Meds/Vitamins/Herbs/Nutritional Supplements/Diet Aids:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Family Medical History

Family Member	Present Age	Age at Death	Medical Problem(s)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Sibling			

Social History

Substance use: ☐ YES ☐ NO
If yes: How many packs per day? _____ How long have you smoked? _____
If no: Have you smoked in the past? ☐ YES ☐ NO If yes, how long? _____
Quit Date: _____

Do you drink alcohol? ☐ YES ☐ NO
If yes: What type of alcohol do you drink? _____
How often? _____ How much at one time? _____

Caffeine use: How much of the following beverages do you drink daily?
Coffee _____ Diet Soda _____
Tea _____ Regular Soda _____

Occupation: What is your occupation? _____
Would you describe your job activity as?
☐ Sedentary ☐ Light Activity ☐ Moderate Activity ☐ Heavy Activity
Do you enjoy your job? _____

Family: Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed
Number and ages of children: _____

PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Current Weight: _____ **lbs.** **Height:** _____**ft.** _____**in.** **BMI:** _____

Weight History:

High School Graduation _____ lbs.
At marriage _____ lbs.
At birth of your first child _____ lbs.
(both men & women)

5 years ago _____ lbs.
1 year ago _____ lbs.
Minimum weight as an adult _____ lbs.
Maximum weight as an adult _____ lbs.
Year: _____

List any medical problems, injuries, or life events that have significantly affected your weight.
Include year and weight change.

1. _____
2. _____
3. _____
4. _____

Diet History:
List of Diets Attempted

Name of Diet	Year(s) Attempted	Length of Diet	Amount Lost
Physician Supervised			
Dietitian Supervised			
Weight Watchers			
LA Weightloss			
Jenny Craig			
Diet Workshop			
Nutrisystem			
Medifast/Optifast			
TOPS			
Overeater's Anonymous			
Richard Simmons			
Atkins Diet			
Carb Addict's			
Self-Directed			
Other:			
Other:			
Other:			

List any medication or diet aids you have tried for the purpose of losing weight:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

In your opinion, what contributes to your excess weight?

☐ Portion sizes ☐ Compulsive eating ☐ Nervous eating ☐ Emotional eating
☐ Stress ☐ Lack of exercise ☐ Eating too much fat & sugar or calorie dense foods

PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Psychological/Support

Have you ever been diagnosed with a psychiatric condition? ☐ YES ☐ NO

Have you ever been hospitalized for a psychiatric condition? ☐ YES ☐ NO

Do you or have you ever had history of: ☐ Binge eating ☐ Laxative use to control weight ☐ Compulsive eating
☐ Bulimia – binge eating followed by self-induced vomiting ☐ Self-induced vomiting

Why do you eat? (check all that apply) ☐ Hunger ☐ Boredom ☐ Stress ☐ Guilt ☐ Enjoy taste
☐ Depression ☐ Anger ☐ Control Other

Which of the following are major stresses in your life? (check all that apply) ☐ Job ☐ Children ☐ Lack of available time
☐ Spouse ☐ Running household ☐ Medical problems

Have you ever had psychological counseling for weight management? ☐ YES ☐ NO

How would you rate your self-esteem? ☐ High ☐ Fair ☐ Low

Goals:

What are your goals in the following areas?

	Amount of weight lost	Fitness/Health goals
In one month	_____	_____
3 months	_____	_____
6 months	_____	_____
1 year	_____	_____
Target weight	_____	_____

Do you feel you will be able to perform the work and have the dedication to achieve these goals? ☐ YES ☐ NO

Comments and Concerns

Please write any concerns, questions, or comments you have relating to this questionnaire or any concerns about participating in a weight management program.

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT QUESTIONNAIRE

NAME: _____ DATE COMPLETED: _____

Sleep Apnea

Have you ever been tested for sleep apnea?	☐ YES	☐ NO
STOP		
Do you snore loudly?	☐ YES	☐ NO
Day time fatigue, feeling tired or sleepy?	☐ YES	☐ NO
Have you been observed stopping breathing or gasping/choking at night?	☐ YES	☐ NO
Are you being treated for high blood pressure?	☐ YES	☐ NO
BANG		
BMI >35?	☐ YES	☐ NO
Age greater than 50?	☐ YES	☐ NO
Neck circumference >17 in. male, >16 in. female	☐ YES	☐ NO
Male Gender?	☐ YES	☐ NO

For general population Low risk of OSA: Yes to 0-2 questions Intermediate risk of OSA: Yes to 3-4 questions High risk of OSA: Yes to 5-8 questions or Yes to 2 or more of 4 STOP questions + male gender or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m2 or Yes to 2 or more of 4 STOP questions + neck circumference

Gastroesophageal Reflux Disease

Do you frequently suffer from heartburn or indigestion?	☐ YES	☐ NO
Do you frequently use antacids or prescribed medications?	☐ YES	☐ NO
Have you ever had an Upper GI or Endoscopy?	☐ YES	☐ NO
Do you wake up at night with indigestion?	☐ YES	☐ NO