Advanced Bariatric Center

Comprehensive Medical Weight Management Program

Patient Data Questionnaire

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Please take the opportunity to completely fill out the following questionnaire regarding your health, weight, dieting, exercise and family history. This information gathered will be used to formulate the optimal comprehensive dietary, fitness, psychological and medical plan.

The WALI is designed to obtain information about your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Please complete the questionnaire carefully and make your best guess when unsure of the answer. Feel free to use the margins and bottom of pages when you need more space for your answers. You will have an opportunity to review your answers with a member of our professional staff.

Please allow 60-90 minutes to complete this questionnaire. Your answers will help us better identify problem areas and plan your treatment accordingly. Please be assured that the information you provide will be kept confidential and will only be available to the treatment staff. Thank you for taking the time to complete this questionnaire.

SECTION A: IDENTIFYING INFORMATION

_____
[1] Name

_____ _____ _____lbs. _____ft. _____inches
[2] Date of Birth [3] Age [4] Weight [5] Height

_____
[6] Address

_____ _____ _____/_____ yrs.
[7] Phone: Day [8] Evening [9] Occupation/# of yrs. at job

_____ _____
[10] Social Security # [11] Today's Date

[12] Highest year of school completed: (Circle one.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Masters Doctorate
High School College

[13] Ethnicity (Circle all that apply.): American Indian Asian African American Hispanic White Other: _____

[14] How did you hear about our program? (Check all that apply.)

_____ Newspaper _____ Physician _____ Other Professional _____Website

_____ Friend _____ Employer _____ Other (Please Specify)_____

SECTION B: WEIGHT HISTORY

1. At what age were you first overweight by 10 lbs. or more? _____ yrs. old
   How do you remember that you were overweight at this time? (e.g., pictures, clothing size, others telling you)
   _____

2. What has been your highest weight after age 21? _____ lbs. _____ yrs. old

3. What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs. _____ yrs. old, maintained for _____ yrs.
   Was this weight reached after a weight loss effort? (Circle one.) Yes No

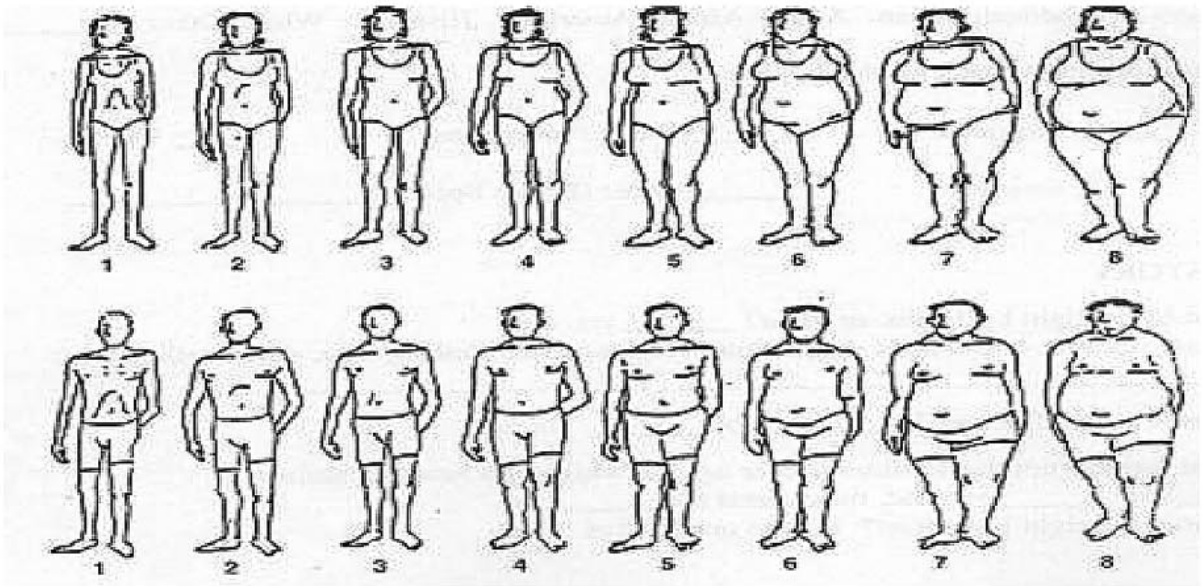
4. Circle the number of the statement that best describes you. "During the past 6 months my weight has…"

   1. decreased more than 10 lbs. or more
   2. decreased by 5 to 10 lbs.
   3. been relatively stable
   4. increased by 5 to 10 lbs.
   5. increased by more than 10 lbs. or more

5. What was your weight: 6 months ago? _____ lbs. 1 year ago? _____ lbs. 2 years ago? _____ lbs.

6. For each time period shown below, please list your maximum weight. If you cannot remember what your maximum weight was, make your best guess and mark "G" (for guess) next to your answer. In addition, please note any events related to your gaining weight during this period. For ages 16 and beyond, please identify the figure, from those shown below, that most resembles your figure at that time. Record the number of the figure.

	AGE	MAXIMUM WEIGHT	FIGURE #	EVENTS RELATED TO WEIGHT GAIN
a.	5-10			
b.	11-15			
c.	16-20			
d.	21-25			
e.	26-30			
f.	31-35			
g.	36-40			
h.	41-50			
i.	51-60			
j.	60-70			



SECTION C: FAMILY WEIGHT HISTORY

1. Please indicate the average height and weight of your biological mother and father during their middle-age years. Also, please select from the figures on the previous page, the one that is most similar to your parents' body shapes. If you do not know your biological parents' height and weight, please mark NA (not applicable) in the spaces.

Parent	Height (ft.+in.)	Weight (lbs.)	Current Age or year of death	Figure # (from previous page)
a. Mother	_____	_____	_____	_____
b. Father	_____	_____	_____	_____

2. Please indicate the height and weight of the following members of your immediate family. Indicate any half-brothers or half-sisters.

Family Member	Height (ft.+in.)	Weight (lbs.)	Current Age or year of death	Figure # (from previous page)
a. Spouse/ Significant Other	_____	_____	_____	_____
b. Oldest brother	_____	_____	_____	_____
c. 2nd oldest brother	_____	_____	_____	_____
d. 3rd oldest brother	_____	_____	_____	_____
e. Oldest sister	_____	_____	_____	_____
f. 2nd oldest sister	_____	_____	_____	_____
g. 3rd oldest sister	_____	_____	_____	_____

SECTION D: WEIGHT, PREGNANCY, AND MENSTRUAL CYCLE

(*For Women Only)*

1. Have you borne children? (Circle one.) Yes No

If yes,

a. What was your weight at the start of your pregnancy? _____lbs.
What was your weight at delivery? _____lbs.
What was your lowest weight after delivery? _____lbs.

b. What was your weight at the start of your second pregnancy? _____lbs.
What was your weight at delivery? _____lbs.
What was your lowest weight after delivery? _____lbs.

c. What was your weight at the start of your third pregnancy? _____lbs.
What was your weight at delivery? _____lbs.
What was your lowest weight after delivery? _____lbs.

d. What was your weight at the start of your fourth pregnancy? _____lbs.
What was your weight at delivery? _____lbs.
What was your lowest weight after delivery? _____lbs.

Please turn to the last page if you need more space.

2. Do you experience a regular menstrual cycle? (Circle one.) Yes No
If yes,
   a. Describe your eating around the time of your menstruation? (Circle one.)
      Eat much less Eat less No Change Eat More Eat Much More

   b. Do you crave particular foods around the time of your menstruation? (Circle one.) Yes No

   c. If yes, which foods do you crave?

_____

_____

SECTION E: WEIGHT LOSS HISTORY

1. Please record your major weight loss efforts, (i.e., diet, exercise, moderation, etc.) which resulted in a weight loss of 10 pounds or more. Take time to think over your previous efforts, starting with the first one, whether in childhood or adulthood. You may have difficulty remembering this information at first, but most people can if they take their time. Start with your first weight loss effort and proceed in order until you reach your most recent one.

	Age at time of effort	Weight at start of effort	# lbs. lost	Method used to lose weight
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____
e.	_____	_____	_____	_____
f.	_____	_____	_____	_____
g.	_____	_____	_____	_____
h.	_____	_____	_____	_____
i.	_____	_____	_____	_____
j.	_____	_____	_____	_____

Please turn to the last page if you need additional space.

2. Please pick a number from 1 to 10 to indicate below how accurate you think you were in remembering and recording your weight loss history. Pick any number from 1 to 10:

1= not at all accurate and 10=completely accurate. Your number is:_____

3. In the past year, how many times have you started a weight loss program on your own that lasted for more than 3 days?_____

4. In the past year, how many times have you started a weight loss program that lasted for 3 days or less? _____

5. Have you ever experienced any significant physical or emotional symptoms while attempting to lose weight or after losing weight? (Circle one.) Yes No

   If yes, please describe your symptoms, how long they lasted and the type of professional help sought, if any.

Problem	Year	Duration (wks.)	Type of Professional Help

SECTION F: WEIGHT LOSS GOALS

1. How much weight would you like to lose at this time? _____ lbs.

2. This would bring you down to a body weight of _____ lbs.

3. When did you last weigh this amount? _____

4. How long was this weight maintained? _____ months

5. Was it achieved after a weight loss effort? (Circle one.) Yes No

6. If you are successful in our program, in changing your eating and exercise habits, how much weight do you realistically expect to lose after:

   a. 6 months _____lbs. b. 12 months _____lbs. c. 24 months _____lbs.

SECTION G: TOBACCO AND ALCOHOL USE

1. Do you currently smoke cigarettes? (Circle one.) Yes No
   If yes,
   a. How many do you smoke a day? _____
   b. How many years have you smoked? _____

2. Have you ever smoked cigarettes and stopped? (Circle one.) Yes No
   If yes,
   a. When did you stop smoking? _____
   b. How many cigarettes did you smoke? _____/day
   c. Did you experience any weight gain after stopping smoking? (Circle one.) Yes No
      If yes, how many pounds? _____

3. During the past year:

   a. How many glasses of wine did you typically drink a week? _____

   b. How many bottles of beer did you typically drink a week? _____

   c. How many mixed drinks or liqueurs did you typically have a week? _____

4. Have you ever had a problem with alcohol consumption or the use of other drugs? (Circle one.) Yes No

a. If yes, please describe the problem and any help you received for it.

_____

_____

_____

_____

SECTION H: EATING HABITS

1. Please indicate the degree to which you believe each of the following behaviors causes you to gain weight. In answering these questions, please use the 5-point scale below. Pick the one number that best describes how much the behavior contributes to your increased weight:

   1. does not contribute at all
   2. contributes a small amount
   3. contributes a moderate amount
   4. contributes a large amount
   5. contributes the greatest amount

_____ a.	Eating with family/friends	_____m.	Eating while cooking/preparing food
_____ b.	Eating when socializing/celebrating	_____ n.	Eating when stressed
_____ c.	Eating at business functions	_____ o.	Eating when depressed/upset
_____ d.	Eating when happy	_____ p.	Eating when angry
_____ e.	Eating in response to sight or smell of food	_____q.	Eating when anxious
_____ f.	Eating because of the good taste of foods	_____ r.	Eating when alone
_____ g.	Eating because I can't stop once I've begun	_____ s.	Eating when bored
_____ h.	Overeating at dinner	_____ t.	Eating when tired
_____ i.	Eating too much food	_____ u.	Overeating at lunch
_____ j.	Continuing to eat because I don't feel full after a meal	_____ v.	Overeating at breakfast
		_____ w.	Snacking after dinner
_____ k.	Eating because I crave certain foods	_____ x.	Snacking between meals
_____ l.	Eating because I feel physically hungry		

Please indicate any other factors that contribute a moderate amount or more to your weight gain.

_____

_____

2. How many days a week do you eat the following meals? Write the number of days in the space and the usual time of each meal.

   a. Breakfast _____ days a week Time: _____ Morning Snack _____ days a week Time: _____

   b. Lunch _____ days a week Time: _____ Afternoon Snack _____ days a week Time: _____

   c. Dinner _____ days a week Time: _____ Evening Snack _____ days a week Time: _____

3. Who prepares meals at your home? _____

4. Who does the food shopping? _____

5. Please list your five favorite foods: _____

_____

6. Do you have any food allergies? (Circle one.) Yes No
   If yes, please specify the food and the allergic reactions.

7. Please specify the amount (in cups, 8 oz.) of the following fluids you typically consume a day.

_____ skim milk	_____ low fat milk	_____ whole milk	_____seltzer water	
_____ fruit juice	_____ diet soda	_____ tea	_____coffee	_____ beer
_____ water	_____ regular soda	_____ wine	_____ hard liquor	_____ other

8. 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

9. During a typical week, how many meals do you eat at a traditional restaurant, coffee shop, cafeteria, or similar establishment?

   Breakfast _____ meals a week

   Lunch _____ meals a week

   Dinner _____ meals a week

10. How many times a week do you typically eat out with others (including family)? _____

SECTION I: FOOD INTAKE RECALL

Please indicate the foods you consume on a typical weekday.

Meal	Time	Location	Food and Beverages Consumed	Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

Please indicate the foods you consume on a typical weekend day.

Meal	Time	Location	Food and Beverages Consumed	Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

SECTION J: EATING PATTERNS I

The Questionnaire on Eating and Weight Patterns-Revised is reprinted here from Yanovski, S.Z. (1993). Obesity Research, 1, 306-324.

1. During the past 6 months, did you often eat an unusually large amount of food within a two hour period (an amount that most people would agree is unusually large)? (Circle one.) Yes No

2. 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? (Circle one.) Yes No

IF NO, SKIP TO QUESTION 11 in this section. Do not complete questions 3-10.

3. During the past 6 months, how often, on average, did you have times when you ate unusually large amounts of food and felt that your eating was out of control? (There may have been some weeks when it was not present- just average those in.) (Circle one.)

   a. Less than one day a week
   b. One day a week
   c. Two or three days a week
   d. Four or five days a week
   e. Nearly every day

4. Did you usually have any of the following experiences during these occasions? Complete all items.

a. Eating much more rapidly than usual? (Circle one.)	Yes	No
b. Eating until you felt uncomfortably full? (Circle one.)	Yes	No
c. Eating large amounts of food when you didn't feel physically hungry? (Circle one.)	Yes	No
d. Eating alone because you were embarrassed by how much you were eating? (Circle one.)	Yes	No
e. Feeling disgusted with yourself, depressed or feeling very guilty after overeating? (Circle one.)	Yes	No
f. Eating large amounts of food throughout the day with no planned mealtimes? (Circle one.)	Yes	No

5. Think about a typical time when you ate this way (that is, large amounts of food and feeling that your eating was out of control).

   What time of day did the episode start? (Circle one.)
   a. Morning (8 AM to 12 Noon)
   b. Early afternoon (12 Noon to 4 PM)
   c. Late afternoon (4 PM to 7 PM)
   d. Evening (7 PM to 10 PM)
   e. Night (After 10 PM)

6. Approximately how long did this episode of eating last, from the time you started to eat until when you stopped and did not eat again for at least two hours? _____ hours _____ minutes

7. As best as you can remember, please list everything you might have eaten or drunk during that episode. If you ate for more than two hours, describe the food eaten and liquids drunk that you ate the most. Be specific- include amounts and brand names (when possible). Estimate as best as you can.

   For example: 7 ounces Ruffles potato chips; 1 cup Breyer's chocolate ice cream with 2 teaspoons of hot fudge; two 8-ounce glasses of Coca-Cola; and 1 ½ ham and cheese sandwiches with mustard.

FOOD	AMOUNT	BRAND (if possible)

8. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?
_____ hours _____ minutes

9. In general, during the past 6 months, how upset were you by overeating episodes in which you ate unusually large amounts of food? (Circle one.)

a. Not at all
b. Slightly
c. Moderately
d. Greatly
e. Extremely

10. In general, during the past 6 months, how upset were you by feeling that you could not stop eating or could not control what or how you were eating? (Circle one.)

a. Not at all
b. Slightly
c. Moderately
d. Greatly
e. Extremely

11. In general, during the past 6 months, how important has your weight or shape been in how you feel about or evaluate yourself as a person-compared to other aspects of your life (i.e. how you do at work, as a parent, or how you get along with other people)?

Weight and shape…
a. were not very important
b. played a part in how I felt about myself
c. were among the main things that affected how I felt about myself
d. were the most important things that affected how I felt about myself

12. During the past 3 months, did you ever make yourself vomit in order to avoid gaining weight after binge eating? (Circle one.) Yes No

If Yes: How often, on average, was that? (Circle one.)
a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

13. During the past 3 months, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating? (Circle one.) Yes No

If Yes: How often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

14. During the past 3 months, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating? (Circle one.) Yes No

If Yes: How often, on average, was that?

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

15. During the past 3 months, did you ever fast (not eat anything at all for at least 24 hours) in order to avoid gaining weight after binge eating? (Circle one.) Yes No

If Yes: How often, on average, was that?

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

16. During the past 3 months, did you ever exercise for more than one hour specifically in order to avoid gaining weight after eating? (Circle one.) Yes No

If Yes: How often, on average, was that?

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

17. During the past 3 months, did you ever take more than twice the recommended dosage of a diet pill in order to avoid gaining weight after binge eating? (Circle one.) Yes No

If Yes: How often, on average, was that?

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

SECTION K: EATING PATTERNS II

Directions: Please circle ONE answer for each question.

1. How hungry are you usually in the morning?

0	1	2	3	4
Not at all	A little	Somewhat	Moderately	Very

2. When do you usually eat for the first time?

0	1	2	3	4
Before 9AM	9:01 to 12 PM	12:01 to 3PM	3:01 to 6PM	6:01 or later

3. Do you have cravings or urges to eat snacks after supper, but before bedtime?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

4. How much control do you have over your eating between supper and bedtime?

0	1	2	3	4
Not at all	A little	Some	Very much	Complete

5. How much of your daily food intake do you consume *after* suppertime?

0	1	2	3	4
0% (none)	1-25% (up to a quarter)	26-50% (about half)	51-75% (more than half)	76-100% (almost all)

6. Are you currently feeling blue or down in the dumps?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely

7. When you are feeling blue, is your mood lower in the:

0	1	2	3	4
Early Morning	Late Morning	Afternoon	Early Evening	Late Evening/Night

_____Check here if your mood does not change during the day.

8. How often do you have trouble getting to sleep?

0	1	2	3	4
Never	Sometimes	About half the time	Usually	Always

9. Other than only to use the bathroom, how often do you get up at least once in the middle of the night?

0	1	2	3	4
Never	Less than once a week	About once a week	More than once a week	Every night

********** ***IF O ON #9, PLEASE STOP HERE*** **********

10. Do you have cravings or urges to eat snacks when you wake up at night?

0	1	2	3	4
Not at all so	A little	Somewhat	Very much so	Extremely

11. Do you need to eat in order to get back to sleep when you awake at night?

0	1	2	3	4
Not at all so	A little	Somewhat	Very much so	Extremely

12. When you get up in the middle of the night, how often do you snack?

0	1	2	3	4

Never	Sometimes	About half the time	Usually	Always

********** *IF O ON #12, PLEASE SKIP TO #15* **********

13. When you snack in the middle of the night, how aware are you of your eating?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Completely

14. How much control do you have over your eating while you are up at night?

0	1	2	3	4
None at all	A little	Some	Very much	Complete

15. How long have your difficulties with night eating been going on?
_____ months _____ years

The Night Eating Questionnaire is reprinted here from:
Allison KC, Stunkard AJ, Thier SL. Overcoming Night Eating Syndrome: A step-by-step guide to breaking the cycle. Oakland, CA: New Harbinger, 2004.

SECTION L: PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity? (Check one.)
_____ not at all
_____ slightly
_____ moderately
_____ greatly

2. Do you have any physical problems that limit your physical activity? (Circle one.) Yes No
If yes, please describe. _____
_____

3. Please check the types of physical activity that you enjoy. Check only those that you have participated in during the last year.

___ a. walking outside	___ e. biking outside	___ h. tennis/racket sports	___ k. golf
___ b. walking (indoors, including treadmill)	___ f. biking (stationary)	___ i. swimming	___ l. dancing
___ c. jogging	___ g. aerobic class	___ j. basketball	___ m. strength training
___ d. running			

___ n. other, Please describe _____

4. For your most preferred activity, how many times have you participated in this activity in the past 6 months?
_____ times

5. How many hours of TV do you watch on an average weekday? _____ hours

6. How many hours of TV do you watch on an average weekend day? _____ hours

7. Approximately how many city blocks or the equivalent do you regularly walk each day? _____ blocks
(12 blocks = 1 mile)

8. How many flights of stairs do you climb up each day? _____ flights a day (1 flight = 10 steps)

9. Please describe your daily lifestyle activity (i.e., how active you are) by picking any number from 1 to 10 in which 1 = very sedentary and 10 = very active. Your number is: _____

SECTION M: FAMILY AND LIVING ARRANGEMENTS

1. I am currently: (Check one.)
   _____ Single
   _____ Married
   _____ Divorced
   _____ Separated
   _____ Widowed

2. Currently, I am: (Check all that apply.)
   _____ living alone
   _____ living with a spouse/partner
   _____ living with a significant other
   _____ living with children
   _____ living with parents/step-parents
   _____ living with other relatives
   _____ living with roommates

3. Please indicate the total number of persons living in your home. _____

4. If you are currently involved in an intimate relationship (significant other), please answer these questions. What is this person's attitude towards your efforts to lose weight? (Circle one)

   a. strongly supports my efforts
   b. supports my efforts
   c. neutral
   d. opposes my efforts
   e. strongly opposes my efforts

   f. Please describe briefly what this person does either to help or hinder your efforts to lose weight.

   _____

   _____

5. How satisfied are you with your overall relationship with this person? (Circle one.)

   a. very satisfied
   b. satisfied
   c. neutral
   d. dissatisfied
   e. very dissatisfied

6. Will other people support your efforts to lose weight? (Circle one.) Yes No
   If yes, how many people will? _____ Who are these people? _____

   _____

   a. How many of these people are actively helpful to you? _____

7. How many people do you talk with about your weight when you are upset about it? _____
   a. How many of these people are helpful to you? _____

8. Will other people oppose or undermine your efforts to lose weight? (Circle one.) Yes No
   If yes, how many will? _____

   a. Who are these people? _____

   _____

   _____

SECTION N: SELF-PERCEPTIONS

1. How satisfied are you with your current weight? (Check one.)
   _____ very satisfied
   _____ moderately satisfied
   _____ slightly satisfied
   _____ neutral
   _____ slightly dissatisfied
   _____ moderately dissatisfied
   _____ very dissatisfied

2. How satisfied are you with your current shape (i.e., figure or physique)? (Check one.)
   _____ very satisfied
   _____ moderately satisfied
   _____ slightly satisfied
   _____ neutral
   _____ slightly dissatisfied
   _____ moderately dissatisfied
   _____ very dissatisfied

3. How satisfied are you with your current overall appearance?
   _____ very satisfied
   _____ moderately satisfied
   _____ slightly satisfied
   _____ neutral
   _____ slightly dissatisfied
   _____ moderately dissatisfied
   _____ very dissatisfied

4. Pick the one sentence that best describes your overall feelings about yourself. "In general, I am…" (Check one.)
   _____ very happy with who I am
   _____ happy with who I am
   _____ ok with who I am but have some mixed feelings
   _____ unhappy with who I am
   _____ very unhappy with who I am

5. "As compared with most people, I think I have…" (Check one.)
   _____ very good self-esteem
   _____ good self-esteem
   _____ average self-esteem
   _____ poor self-esteem
   _____ very poor self-esteem

6. Pick the one sentence that best describes your feelings about the way you looked the last time you lost a lot of weight. "I was…" (Check one.)
   _____ very happy with the way I looked
   _____ happy with the way I looked
   _____ ok with the way I looked, but with some mixed feelings
   _____ unhappy with the way I looked
   _____ very unhappy with the way I looked

7. How much weight did you lose? _____ lbs. At what weight did you start to diet during this time? _____ lbs.

SECTION O: PSYCHOLOGICAL FACTORS

1. Have you ever had any problems at any time with depression, anxiety, or other emotions that disrupted your normal functioning? (Circle one.) Yes No

2. Have you ever sought professional help for emotional problems? If yes, specify below.

Problem	Year	Duration (wks.)	Type of Professional Help

3. During the past month, have you felt depressed, sad, or blue much of the time? (Circle one.) Yes No

4. During the past month, have you often felt hopeless about the future? (Circle one.) Yes No

5. During the past month, have you had little interest or pleasure in doing things? (Circle one.) Yes No

6. Have you ever been subjected to physical abuse? (Circle one.) Yes No

7. Have you ever been subjected to sexual abuse? (Circle one.) Yes No

8. Are any of your immediate family members alcoholic? (Circle one.) Yes No

SECTION P: TIMING

1. Please indicate if you are currently experiencing any greater than usual stress in your life related to the following events.
   Complete each item by circling the appropriate box.
   a. Work: (Circle one.) Yes No
   b. Health: (Circle one.) Yes No
   c. Relationship with spouse/significant other: (Circle one.) Yes No
   d. Activities related to your children: (Circle one.) Yes No
   e. Activities related to your parents: (Circle one.) Yes No
   f. Legal/financial trouble: (Circle one.) Yes No
   g. School: (Circle one.) Yes No
   h. Moving: (Circle one.) Yes No
   i. Other: _____

   Please explain in a sentence any items to which you responded yes:

   _____

   _____

   _____

2. Are you planning any major life changes (i.e., new job, moving, relationship, etc.) during the next 6 months? (Circle one.) Yes No

If yes, please briefly describe below:

_____

3. How stressful has your life been during the past 6 months? (Circle one.)

    1. much less stressful than usual
    2. less stressful than usual
    3. average level of stress
    4. more stressful than usual
    5. much more stressful than usual

4. How stressful do you think that your life will be in the next 6 months, excluding your efforts to lose weight. Pick a number from above. _____

5. 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 have ever had. Your number is: _____

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

    _____

    _____

    _____

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

    _____

    _____

    _____

8. 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 can definitely find 30 minutes daily for weight control.

    _____ 4. I can devote more than 30 minutes daily to weight control.

9. 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 all confident and 10 = extremely confident. Your number is: _____

SECTION Q: MEDICAL HISTORY

1. MEDICATIONS YOU TAKE (daily, occasionally, or "as needed").
Include both prescription and non-prescription drugs**,** and vitamins, supplements, herbal products, etc.

Name of Medication	Strength	Dose	Reason for taking

2. SURGICAL HISTORY Please list surgeries you have had.

TYPE OF SURGERY	YEAR

3. PSYCHIATRIC HISTORY

Have you been evaluated for psychological problems causing your obesity?

YES ☐ NO ☐ Results:

Have you ever seen a psychologist/psychiatrist/therapist in the past?

YES ☐ NO ☐ If so, for what reason and when?

Are you currently seeing a psychologist/psychiatrist/therapist?

YES ☐ NO ☐ Reason:

4. ALLERGIES TO MEDICATIONS

Name of Medication **Reaction it causes** (Ex.: rash, swelling)

_____

_____

_____

_____

Problems with anesthesia? YES ☐ NO ☐

If YES, describe:

_____

_____

_____

_____

_____

_____

5. THYROID PROBLEMS

Have you been tested for thyroid problems? YES ☐ NO ☐

Have you ever had thyroid problems? YES ☐ NO ☐

Are you taking thyroid medication? YES ☐ NO ☐

If you are taking thyroid medication, has it affected your weight

(i.e., gained or lost weight)? YES ☐ NO ☐

If so, describe:_____

6. COMORBID FACTORS — Weight-Related Medical Problems

Please read carefully and make sure you mark the appropriate box.

MEDICAL PROBLEM	YES	NO	NOT SURE	I TAKE MEDICINE FOR THIS YES	NO
High Blood Pressure	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Fatty Liver (*hepatic steatosis)*	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Asthma (not to be confused with allergies)	☐	☐	☐	☐	☐
Sleep Apnea(documented) Use CPAP: Yes _ No _	☐	☐	☐	☐	☐
Sleep Apnea (un-documented)	☐	☐	☐	☐	☐
Reflux *(GERD, frequent heartburn)*	☐	☐	☐	☐	☐
Urinary Incontinence *(can't hold urine)* Use pads for this?	☐	☐	☐	☐	☐
Degenerative Joint Disease (DJD)	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Joint Pain (back, knees, ...)	☐	☐	☐	☐	☐

MEDICAL PROBLEM (cont'd.)	**YES**	**NO**	**NOT SURE**	**I TAKE MEDICINE FOR THIS YES**	**NO**
Heel Spurs	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Varicose Veins Painful?	☐	☐	☐	☐	☐
Rashes Due to Skin Folds	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
FEMALES:					
Infertility (if not from tubal ligation, menopause, or hysterectomy)	☐	☐	☐	☐	☐
Irregular Periods	☐	☐	☐	☐	☐
Polycystic Ovarian Disease	☐	☐	☐	☐	☐
Excessive Amount of Hair	☐	☐	☐	☐	☐

Face ☐ Body ☐

Have you been diagnosed with hirsutism? YES ☐ NO ☐

7. Use the following lines to give **details or descriptions** about medical conditions mentioned on the previous page, or other medical conditions, that you feel should be known to your doctor. *(ex.: Incontinence--Only when I cough, sneeze, or laugh.)*

_____

_____

_____

_____

_____

8. If you get frequent pain in any of the following areas, please mark the appropriate box.

PAIN IS:	**Mild** *(Not Bad)*	**Moderate** *(Pretty Bad)*	**Severe** *(Very Bad)*	**I take medicine for this**
NECK	☐	☐	☐	☐
BACK	☐	☐	☐	☐
HIPS	☐	☐	☐	☐
LEGS	☐	☐	☐	☐
KNEES	☐	☐	☐	☐
ANKLES	☐	☐	☐	☐
FEET	☐	☐	☐	☐

If you get **swelling** in any of the areas listed ABOVE, please **circle** the ones that apply.

9. MORE MEDICAL HISTORY

Do you have, or have you ever had, any of the following. Please mark YES or NO.

	YES	**NO**
Convulsions/Seizures	☐	☐
Bleeding Tendency	☐	☐
Acute Infection	☐	☐
Hepatitis	☐	☐
Type:		
Diabetes	☐	☐
On insulin?	☐	☐
Gestational Diabetes	☐	☐
Year:		
Cancer	☐	☐
Year:		

Specify type/location: _____

10. MEDICAL PROBLEMS WE FORGOT TO MENTION

Are there any medical problems or symptoms not mentioned in this form you feel your doctor should know about? **YES** ☐ **NO** ☐

Describe/Explain:

11. LIST THE DOCTORS YOU SEE, their area of specialty, and the problems you see them for.

SECTION R: DIETARY MEDICATION HISTORY

1. List **DIETS** you have tried (medications BELOW) starting with the most recent. (Examples: Weight Watchers, Atkins, Slim Fast, Pritikin, Jenny Craig, diabetic diet, low carbohydrate, liquid, etc.) Give **DATES** in month/year and **amount of weight lost FOR THE PAST TWO YEARS**. For older diets just give the name or description of diets.

DIET	STARTED	STOPPED	WT. LOST	WT. GAINED BACK (Some/All/More)
Ex: Pritikin	*02/99*	*08/99*	*22 lbs*	*More*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

DIET MEDICATION	STARTED	STOPPED	WT. LOST	WT. GAINED BACK
Ex: Phentermine	*08/99*	*02/00*	*40 lbs*	*More*
1.				
2.				
3.				

Have you ever taken Fen-Phen, Redux, or Pondimin? YES ☐ NO ☐

Circle which apply. When? _____ How long? _____

2. ATTEMPTED WEIGHT LOSS METHODS

Please check all of the following methods you have tried:

METHOD	YES	NO	METHOD	YES	NO
Diets	☐	☐	Exercise	☐	☐
Counseling	☐	☐	Hypnosis	☐	☐
Diet medicines (prescription)	☐	☐	Diet medicines (non-prescription)	☐	☐
Ear staple/ acupuncture	☐	☐	Fasting/ starvation	☐	☐
Support Group	☐	☐	Injections	☐	☐

Other methods of weight loss tried:

3. Worked on weight loss with a **doctor**:

YES ☐ NO ☐ Year(s) _____ Length of Time _____

Names of these doctors:

Worked on weight loss with a **nutritionist**:

YES ☐ NO ☐ Year(s) _____ Length of Time _____

Worked on weight loss with a **dietitian**:

YES ☐ NO ☐ Year(s) _____ Length of Time _____

Do you find it harder to lose weight as you get older? YES ☐ NO ☐

4. TIMECOURSE

Your Age Now: _____ How long have you been overweight: _____

Since age:_____. (OR) For_____years.

Within a 20-pound weight gain or loss, how many months/years have you been at your current weight? _____What has been your heaviest weight? ____lbs. Year:

What has been your largest amount of weight lost throughout your diet history? What year? _____ What weight loss program (diet, medicine, etc.) was that with?

5. WEIGHT LOSS ATTEMPTS

At what age did you start dieting? _____

Please check all that apply.

☐ Diet prescribed by your doctor
☐ Jenny Craig
☐ Diet Center
☐ Atkins
☐ Weight Watchers
☐ Cambridge Diet
☐ Pritikin
☐ Scarsdale Diet
☐ Lean Cuisine
☐ Low-Calorie Diet
☐ Low-Carbohydrate
☐ Low-Fat Diet
☐ High-Protein Diet
☐ Healthy Choice Meals

☐ Nutri-Systems	☐ Prism DieT	☐ Hollywood Diet
☐ TOPS	☐ Fruit Diet	☐ L.A. Weight Loss
☐ Susan Powter	☐ Bahamian Diet	☐ Weight Loss Camp
☐ Diabetic Diet	☐ No-Sugar Diet	☐ Grapefruit Diet
☐ Liquid Diet	☐ Vegetarian Diet	☐ CabbageSoup Diet
☐ Stillman Diet	☐ Diet Teas	☐ South Beach Diet
☐ Mayo Clinic Diet	☐ Rotation Diet	☐ The Zone
☐ Overeaters Anonymous	☐ Richard Simmons Deal-A-Meal	
☐ Weigh Down	☐ Colorad	☐ Choose-To-Lose
☐ Beverly Hills Diet	☐ Dr. Phil's Diet Program	
☐ Inpatient Program for Weight Loss		☐ Body for Life
☐ Fat Trapper	☐ Somersize	☐ Lindora
☐ Physicians Weight Loss Center		
☐ Metabolife	☐ Stacker 2	☐ Slim Fast
☐ California Slim	☐ Acutrim	☐ Cal Ban 3000
☐ Herbalife	☐ Fastin	☐ Redux
☐ Phentermine	☐ Ephedrine	☐ Fen-Phen
☐ Pondimin	☐ Ionamin	☐ Tenuate
☐ Xenical	☐ Meridia	☐ Optifast
☐ Medifast	☐ RX Fast	☐ NestlesSweet Success
☐ B-12 Injections	☐ B-6 Injections	☐ HCG Injections
☐ Body Solutions	☐ Fat Burners	☐ Dexatrim
☐ Chromaslim	☐ Bioslim	☐ Celexa
☐ Diuretics (water pills)	☐ Laxatives	☐ Amphetamines
☐ Purging (self-induced vomiting)		☐ Fasting
☐ Acupuncture/Ear Staple	☐ Body Wraps	☐ Jaw Wiring
☐ Hypnosis	☐ Group Counseling	☐ Individual Counseling
☐ Church Diet Group	☐ Other Diet Group	☐ Joined a Gym
☐ Aerobics Classes	☐ Purchased Exercise Equipment	
☐ Tae Bo	☐ Hired Personal Trainer	☐ Exercise Videotapes
☐ Attended Exercise Classes	☐ Water Aerobics Class	

SECTION S: WEIGHT PROBLEMS OF DAILY LIVING

1. List problems you have **AT YOUR JOB** due to your size, weight, or weight-related physical problems such as shortness of breath. (*Examples: Don't fit in regular office chairs. Cannot easily reach computer keyboard. Sitting for long periods causes back pain, feet swell.)* **Give as many specific examples as possible.**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

2. List problems you have **in your PERSONAL/FAMILY life** due to obesity and related problems. (Examples: Personal hygiene is hard because I cannot reach where I need to. I do not fit into public restrooms. Other examples of difficulties could be: Playing or caring for children, getting out of bathtub, can't bike ride with family, avoid social activities because of embarrassment about your size, doing yard work, housework, bathing, dressing, sex, taking walks, bending.) **Give as many specific examples as possible.**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

SECTION S: SOCIAL HISTORY

1. Marital Status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Children: How many? _____ Ages _____

Stepchildren living with you: How many? _____ Ages _____

Do you take care of young children at home? YES ☐ NO ☐

How many? ____ Ages: _____

2. Employment:

Do you have a job? YES ☐ NO ☐

Self-employed: YES ☐ NO ☐ Full-time ☐ Part-time ☐

What type of work/business? _____

Your title or what you do: _____

Homemaker: YES ☐ NO ☐

Currently on Disability: YES ☐ NO ☐ Permanent ☐ Temporary ☐

Reason for disability: _____

3. Use of alcohol: YES ☐ NO ☐

Estimate how many drinks (**write in a number**): _____

Daily ☐ Monthly ☐ Yearly ☐

Use of tobacco: Never ☐ Current smoker ☐ Ex-Smoker ☐

Age started _____ 1 pack/week☐ 1 pack/day ☐ 2 packs/day ☐ More ☐

Quit smoking in (year) _____ How long did you smoke? _____

Use of recreational drugs: Never☐ Currently ☐

Type/frequency _____

Used in the past: YES ☐ NO ☐ If YES, how long ago? _____

SECTION T: SYSTEMS REVIEW

	YES	NO	Explanation/Details
General			
Good General Health	☐	☐	_____
Recent Weight Changes	☐	☐	_____
Fever	☐	☐	_____
Eyes			
Wear Glasses or Contacts	☐	☐	_____
Past/Present Eye Disease	☐	☐	_____
Transient Blindness	☐	☐	_____

	YES	NO	Explanation/Details
Ears/Nose/Mouth/Throat			
Hearing Loss or Ringing	☐	☐	_____
Chronic Sinus Problems or Rhinitis	☐	☐	_____
Dentures	☐	☐	_____
Nose Bleeds	☐	☐	_____
Cardiovascular			
Heart Attack	☐	☐	_____
Chest Pain	☐	☐	_____
If YES, did you see a doctor for it?	☐	☐	_____

Was it caused by:

Anxiety: ☐ Stomach/gallbladder: ☐

Respiratory (asthma, emphysema): ☐

Did you have tests or treatment for the chest pain? YES ☐ NO ☐

Have you had a cardiac workup within the last year? If so, please give details:

_____

_____

_____

_____

_____

_____

	YES	NO	Explanation/Details
Cardiovascular (continued)			
Shortness of Breath with Exertion	☐	☐	_____
Shortness of Breath with Laying Flat	☐	☐	_____
Swelling of Feet, Ankles, Hands (please circle which)	☐	☐	_____

	YES	NO	Explanation/Details
Respiratory			
Chronic or Frequent Cough	☐	☐	_____
Spitting Up Blood	☐	☐	_____
Asthma	☐	☐	_____
Shortness of Breath	☐	☐	_____
Past TB, Pneumonia, or Valley Fever (circle which)	☐	☐	_____
Gastrointestinal			
Loss of Appetite	☐	☐	_____
Change in Bowel Movements	☐	☐	_____
Rectal Bleeding	☐	☐	_____
Blood in Stool	☐	☐	_____
Stomach Ulcer	☐	☐	_____
Frequent Heartburn	☐	☐	_____
Nausea or Vomiting	☐	☐	_____
Liver Disease	☐	☐	_____
Pancreas Disease (not diabetes)	☐	☐	_____

	YES	NO	Explanation/Details
Genitourinary			
Painful or Burning Urination	☐	☐	_____
Difficulty Urinating	☐	☐	_____
Blood in Urine	☐	☐	_____
Kidney Stones	☐	☐	_____
Testicular Pain	☐	☐	_____
Irregular Periods	☐	☐	_____
Infertility	☐	☐	_____

History of Hysterectomy	☐	☐	_____
Ovaries Removed	☐	☐	_____
Urinary Incontinence	☐	☐	_____
(can't hold urine)			_____

	YES	NO	Explanation/Details
Musculoskeletal			
Joint Pain, Stiffness	☐	☐	_____
Back Pain	☐	☐	_____
Difficulty or Painful Walking	☐	☐	_____

	YES	NO	Explanation/Details
Integumentary (Skin)			
Rash or Itching	☐	☐	_____
Breast Pain	☐	☐	_____
Breast Lump	☐	☐	_____
Change in the Appearance of a Breast	☐	☐	_____
Nipple Discharge	☐	☐	_____

	YES	NO	Explanation/Details
Neurological			
Frequent Headaches	☐	☐	_____
Migraine Headaches	☐	☐	_____
Dizzy/Lightheaded How often?	☐	☐	_____
Numbness/Tingling Where? _____	☐	☐	_____
Tremors	☐	☐	_____
Stroke (Year _____)	☐	☐	_____
Paralysis	☐	☐	_____
Head Injury (Year ____)	☐	☐	_____
Convulsions or Seizures	☐	☐	_____

	YES	NO	Explanation/Details
Endocrine			
Hormone Problems	☐	☐	_____
Thyroid Disease	☐	☐	_____
Diabetes	☐	☐	_____
Excessive Thirst or Urination	☐	☐	_____
Heat or Cold Intolerance	☐	☐	_____

	YES	NO	Explanation/Details
Hematologic/Lymphatic			
Slow to Heal after Cuts	☐	☐	_____
Bleeding Tendency	☐	☐	_____
Bruising Tendency	☐	☐	_____
Anemia	☐	☐	_____
Blood Clots Legs ☐ Lungs ☐	☐	☐	_____
Past Blood Transfusion	☐	☐	_____

The following is space for you to tell us anything we might have missed that you think we should know.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____