Lexington Women's Health Weight Loss Program Questionnaire

IMPORTANT: Please complete this questionnaire prior to your first weight loss visit with our practice. In addition, please bring a current list of your medications (including supplements), medical diagnoses, and a current list of your past surgeries.

Name: ______________________________ DOB: ______________ Age: _______

Occupation: ____________________________ Marital status: ____________________

Primary care provider: ____________________ Current weight: ________ lbs.

Who suggested that you need to lose weight? (Circle all that apply)

Doctor Family member Myself Other: ____________________________________

What is the most important reason you want to lose weight? ______________________________

What is your weight goal? _______ lbs.

What kinds of treatments are you willing to consider? (Circle all that apply)

Lifestyle change Medications for weight loss Weight loss surgery

Others (specify) ____

Date of last EKG: __________________

Weight History:

When did weight become a problem for you? (Please circle)

Childhood Teenage Adult After pregnancy

What events in your life do you think are related to your weight gain?

____

Are any of your family members overweight? Yes No If yes, who? ____________________

What was your highest adult weight? ____ lbs. When? ________ Lowest? ____lbs. When? _______

Were you trying to lose weight at that time? Yes No

What was your weight one year ago? _______ lbs.

What is the maximum amount of weight you've lost in the past? _______ lbs.

What pattern best describes your weight over the past year? (Circle one)

Gaining Losing Stable

Have you ever had weight loss surgery? Yes No

Have you ever taken medications for weight loss? If yes, which medications and when:

____

Have you gained weight after starting a medication in the past? Yes No

Past weight loss attempts

How have you tried to lose weight in the past? How much weight did you lose? How long did you keep it off?

____

What do you feel has been your biggest barrier to losing weight?

____

Are you currently working with a dietitian/nutritionist? Yes No

Eating patterns:

Describe what you eat/drink on a typical 24 hr day from when you wake up until the next morning:

____

____

Who prepares most of your meals? ______________ Who shops for your food? ______________

How often do you eat outside of the home/fast food? ______________________________

Do you skip meals? Yes No If so, which? ______________________________________

Are you allergic or intolerant to any foods? Yes No If so, which? ______________________

Do you feel excessively hungry? Yes No If so, when?______________________________

Do you eat when you are not hungry? Yes No

Do you ever eat and feel like you cannot stop? Yes No

Do you eat large volumes in a short time? Yes No

Have you ever tried to manage your weight by vomiting, using laxatives, diuretics, diet pills, or excessive exercise? Yes No Please explain: ______________________________

Do you get up after you have gone to bed to eat? Yes No If yes, what is the reason for doing so? ____

Exercise or Activity:

How active are you at your job? (Circle one) Sedentary Moderately active Constantly active

What types of exercise do you enjoy? ____

Do you exercise regularly? Yes No

How many times a week? ______________ How many minutes each time? ______________

What type of exercise? ____

Is there anything that keeps you from exercising regularly? ___________________________

Sleep

On average, how many hours of sleep do you get per night? __________

How many times do you wake up at night? ____ Reason for waking up at night? ____________

Generally, do you feel well rested when you wake up in the morning? Yes No

Do you have any difficulty falling asleep? Yes No

Do you take sleep aides? Yes No Do you snore? Yes No

Do you ever wake up at night gasping or with a feeling of choking? Yes No If so, how often does this occur? __________

Do you feel tired or sleepy during the daytime? Yes No

Do you nap during the daytime? Yes No

Have you ever been tested for sleep apnea? Yes No If yes, date tested: ______________

Do you wear a CPAP? Yes No

Stress

On a scale of 1 to 10, how would you rate your stress over the past year? ________________

How do you think the stress is affecting you? ______________________________________

What is causing your stress? ____

Have you used any stress relief techniques in the past? Yes No If so, what? ____________

____