Date:____________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (First)_________________________ (MI)_____ (Last) ___________________________

Date of Birth: _____/_____/__________

Referred By: ____

WEIGHT HISTORY AND HEALTH BEHAVIORS

All questions contained in this questionnaire are optional and will be kept strictly confidential.

WEIGHT HISTORY

1. At what age did weight become a problem for you?

□ Childhood □ Teens □ Adulthood □ Pregnancy □ Menopause

2. Have there been any circumstances or life events that have triggered weight gain for you?

□ Pregnancy □ Job change □ New medication □ Stress □ Boredom

□ Other____

3. What was your weight one year ago? _____ Two years ago? _____ Five years ago? _____

4. What has been your highest weight? _______________________

5. What was your weight around age 20? _____________________

6. Have you lost weight in the past? If so, select from the list the program/method, and how much weight you lost. (Check all that apply):

□ Weight Watchers □ Nutrisystem □ Jenny Craig

□ LA Weight Loss □ Atkins □ South Beach

□ Zone diet □ Medifast □ Dash diet

□ Paleo diet □ HCG diet □ Mediterranean diet

□ Ornish diet □ Other: _________________________________

7. Have you ever used any prescription medications for weight loss? (check all that apply):

□ Phentermine (Adipex) □ Meridia □ Xenecal/Alli □ Phen/Fen

□ Phendimetrazine (Bontril) □ Topamax □ Saxenda □ Diethylpropion

□ Bupropion (Wellbutrin) □ Belviq □ Qsymia □ Contrave

□ Other (including supplements)____

□ 7a. If so, how much weight did you lose with the medication, and did you experience any side effects? ____

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8. How is your weight affecting your health and your life?____
____

9. What do you consider some of your barriers when it comes to managing your weight? (Click all that apply) ◻ Hunger ◻ Cravings ◻ Fatigue ◻ Finances
◻ Time ◻ Knowledge ◻ Other______________________________________

10. What are your goals/anticipated outcomes from this program? _______________________________
____

NUTRITION

1. How do you feel about your current eating habits?
◻ Could be better ◻ Pretty good overall but room for improvement ◻ I have great habits
2. Are you currently following a particular eating plan? ◻ Yes ◻ No. If yes, which one?
◻ Low fat ◻ Low carb ◻ Keto ◻ Mediterranean
◻ Vegan ◻ Other ____
3. Have you tried particular eating plans or diets in the past? ◻ Yes ◻ No
If yes, which ones have you tried, and which ones worked will or did not work for you?
____
4. Number of meals and snacks you eat on an average day:
◻ 3 ◻ 3-5 ◻ 6-8 ◻ 8-10+
5. Food allergies / intolerances (check all that apply):
◻ Gluten ◻ Dairy ◻ Tree nuts ◻ Eggs ◻ Soy ◻ Fish / Shellfish
◻ Other: ____
6. Who does the most of the cooking and/or grocery shopping at your house?
◻ Self ◻ Spouse/Partner ◻ Other member of household ◻ Other
7. Food preferences including ethical or cultural considerations: __________________________________
____
8. How many times per week do you eat food or drink beverages from a restaurant?
◻ Never ◻ 1-3x/week ◻ 4-6x/week ◻ More than 7x/week
9. Triggers for eating (click all that apply:)
◻ Hunger ◻ Stress ◻ Boredom ◻ Cravings
◻ Time of day ◻ Other _______________________________________
10. Barriers to eating healthy (click all that apply):
◻ Cooking skills ◻ Time ◻ Financial reasons ◻ Access to healthy foods
◻ Schedule ◻ Home/work circumstances ◻ Other _______________________

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11. Current or past history of an eating disorder? □ Yes □ No.

If yes, please elaborate: ____

PHYSICAL ACTIVITY

1. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class?

□ Never □ 1-2x/ week □ 3-4x/ week □ 5 or more x/week

2. How many minutes does each bout of exercise typically last?

□ 10 min or less □ 10 min - 20 min □ 20 min - 30 min □ more than 30 min

3. Type of activities you participate in regularly (click all that apply).

□ Walking □ Biking □ Strength training □ Yoga

□ Other ____

4. List any barriers to physical activity. (Time, joint pain, motivation, etc.)

____

5. List equipment / spaces available to you for activity.

□ Gym membership □ stationary bike □ free weights □ walking path

□ Other ____

6. What types of activities do you enjoy or have enjoyed in the past? ____

____

ALCOHOL

1. Do you drink alcohol? □ Yes □ No. If yes, what kind? (Click all that apply)

□ Beer □ Wine □ Liquor □ Cocktails

2. How many drinks per week do you drink?

□ None □ 1-3 □ 4-7 □ more than 8

3. Are you concerned about the amount you drink? □ Yes □ No

CALORIC BEVERAGES

1. Do you drink caloric beverages such as soda, juice, sweetened tea, or coffee with creamer?

□ Yes □ No. If yes, what kind? ____

If yes, what kind(s)?____

How many ounces per day on average?____

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SLEEP

1. How many hours of sleep do you average per night?

  ▫ Less than 5 ▫ 6-8 hours ▫ 9 or more hours

2.Do you work a night shift or shift work? ▫ Yes ▫ No

3. Usual bedtime: _____________ Usual waking time: _____________

4. Do you have trouble falling asleep or staying asleep? ▫ Yes ▫ No

5. Have you ever been evaluated for sleep apnea or other sleep related disorders? ▫ Yes ▫ No.

  If yes, were you diagnosed with sleep apnea? ▫ Yes ▫ No

    If yes, do you use a CPAP, BiPap or other device? ______________________________

6. Do you snore? ▫ Yes ▫ No

7. Are you tired throughout the day? ▫ Yes ▫ No

8. Has anyone observed that you stop breathing during sleep? ▫ Yes ▫ No

9. Do you often wake up with headaches in the morning? ▫ Yes ▫ No

10. Do you take naps during the day? ▫ Yes ▫ No

OCCUPATION AND HOME LIFE

1. How many people live with you in your home? ________________________

2. If there are children in your home, please indicate their ages: _______________________________

3. What is your occupation? ____

4. Do you have good social support for healthy lifestyle changes? ▫ Yes ▫ No

  If so, list your "support people":____

  ____

MENTAL HEALTH

1. Is stress a major problem for you? ▫ Yes ▫ No

  Rate your stress level on a scale from 1 to 10: ___________________

2. Do you feel like you have healthy coping mechanisms for stress? ▫ Yes ▫ No

  How do you cope with your stress? ____

3. Do you consider yourself an "emotional eater"? ▫ Yes ▫ No

4. Do you ever feel depressed? ▫ Yes ▫ No

5. Have you ever been diagnosed with a mental health condition? ▫ Yes ▫ No

  If yes, which mental health condition? ▫ Anxiety ▫ Depression ▫ Bipolar disorder

  Other ____

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6. Do you cry frequently? ◻ Yes ◻ No

7. Have you ever attempted suicide? ◻ Yes ◻ No

8. Have you ever seriously thought about hurting yourself? ◻ Yes ◻ No

9. Have you ever been to a counselor or other mental health professional? ◻ Yes ◻ No

If yes, are you currently receiving counseling? ____

WOMEN ONLY

1. Age at onset of menstruation: _______________

2. Date of last menstruation: ______________

3. Do you have any of the following: heavy periods, irregularity, spotting, pain or discharge?

◻ Yes ◻ No

4. Number of pregnancies ___________ Number of live births ___________

5. Are you pregnant or breastfeeding? ◻ Yes ◻ No

6. Are you planning a pregnancy within the next year? ◻ Yes ◻ No

7. Do you have any problems with urinary or bladder control? ◻ Yes ◻ No

8. Have you ever been diagnosed with PCOS? ◻ Yes ◻ No

9. Have you been affected by infertility? ◻ Yes ◻ No

10. Date of last pap: _____________________

MEN ONLY

1. Do you usually get up to urinate during the night? ◻ Yes ◻ No

If yes, number of times: _____________

2. Any difficulty with erection or ejaculation? ◻ Yes ◻ No

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NUTRITION HISTORY

Please list your food and beverage intake for the past 24 hours.

TIME	FOOD & BEVERAGES CONSUMED	PLACE CONSUMED

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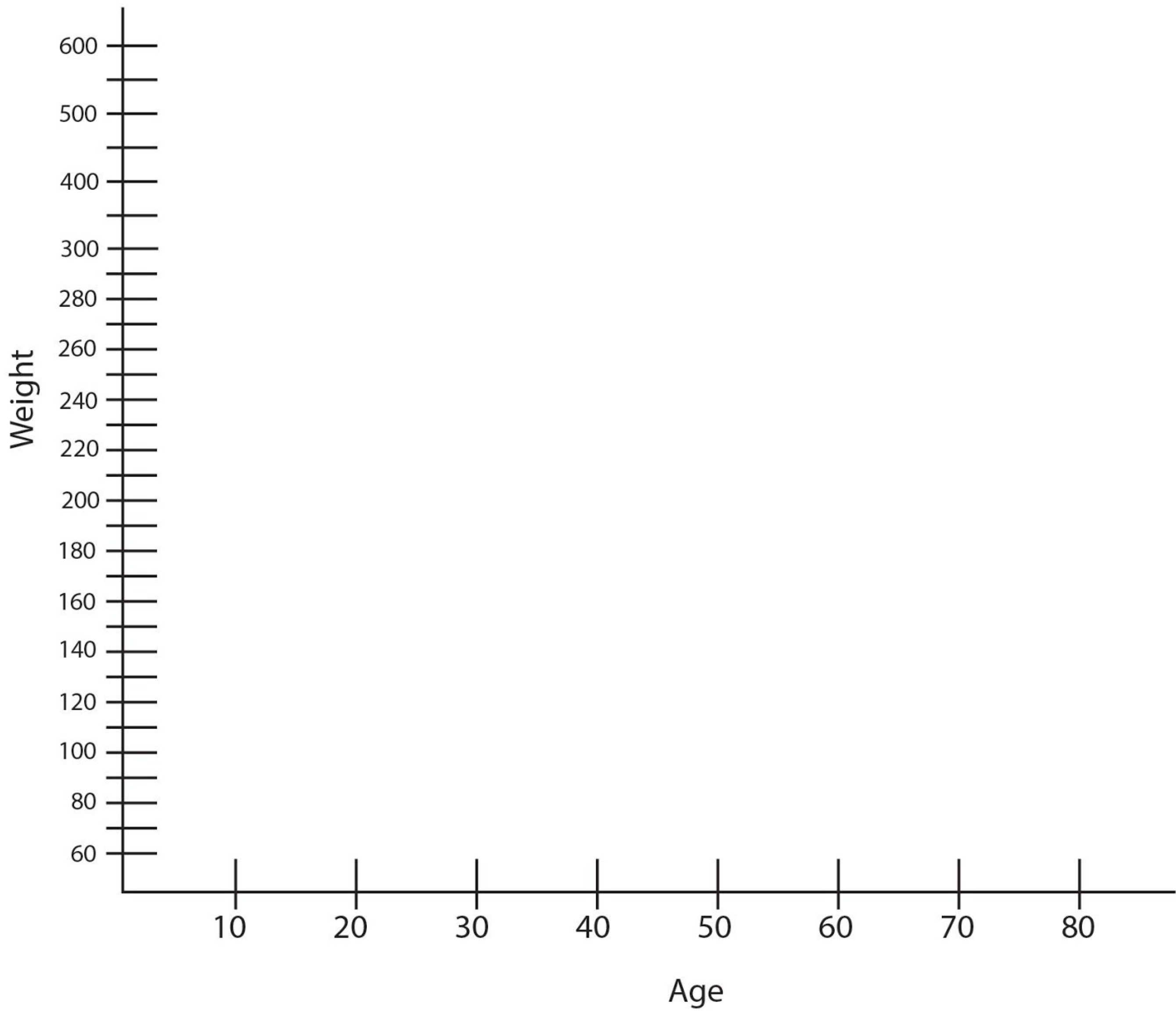
WEIGHT GRAPH

Please chart your age and weight on the chart below.



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