

--- Clinical Nutrition Center ---

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WEIGHT CONTROL QUESTIONNAIRE and MEDICAL HISTORY

This questionnaire is to assist you in giving us information concerning your past weight history, medical history, previous diet attempts, dietary habits, and need for weight control. Please complete ALL questions accurately and as carefully as possible. If a question does not pertain to you, mark it NA (not-applicable). Please fill this questionnaire out when you have plenty of time to do so. DO NOT HURRY THROUGH IT. This will take approximately 20 minutes to complete.

I. GENERAL INFORMATION

Today's Date:

First Name:
Last Name:

Home Phone: (###) ###-####
Work Phone:
Cell Phone:

Street Address:
Apartment Number
City:
State:
Zip Code:
e-mail

Emergency Contact:
Emergency Contact Phone:

Sex (Female or Male): Female Male

Date of Birth (month/day/year):

How did you hear about us?

Marital Status:
Social Security Number:
Occupation:
Employer:
Title / Degree:

II. HEALTH INFORMATION:

Primary Care Physician (PCP):

First Name:
Last Name:
PCP phone number:
PCP Street Address:
PCP Suite / Office Number:
PCP City:

PCP State:

PCP Zip Code:

Please check this box if it is ok with you that we review your care here with your PCP

1. Family History: Please specify pertinent health problems. In particular: heart disease, high blood pressure, diabetes, obesity, cancer, high cholesterol, genetic disease, mental illness, other.

| Relative | Medical Problems: |
|-----------------|--------------------------|
| Mother: | |
| Father: | |
| Sibling: | |
| Sibling: | |
| Child: | |
| Child: | |
| Other: | |

2. Your Health History: Please list any health problems (examples: see family history above, in addition, list any other chronic problems like gastrointestinal, psychiatric, emotional, arthritis, heartburn, back pain, palpitations, etc.)

| <i>Problem</i> | | <i>Problem</i> | |
|----------------|--|----------------|--|
| | | | |
| | | | |
| | | | |

3. Hospitalizations for operations or serious illnesses (do not include pregnancies)

| Year | Operation or Illness |
|-------------|-----------------------------|
| | |
| | |
| | |
| | |

4. Current Health Problems: Please list any current health problems:

| <i>Problem</i> | | <i>Problem</i> | |
|----------------|--|----------------|--|
| | | | |
| | | | |
| | | | |

5. Check This Box if you Smoke

If yes, how many cigarettes per day?

6. List any vitamins, supplements, or over-the-counter medications you take regularly (separate with commas)

7. List below all prescription medications you take regularly. Please include dosage strength, number per day:

8. List medication allergies:

*please list 1 per box
if none, please write None*

9. Women only - Menstrual History

| | | | |
|----------------------------------|--|---------------------------|--|
| Age at onset | | Regular or Irregular | |
| Date of last period | | Cycle: number of days | |
| Do you take birth control pills? | | Flow: (light, med, heavy) | |
| Date of last pap smear | | Pap result (?Normal) | |
| Date of last mammogram | | Mammogram result | |
| Number of pregnancies | | Number of live births | |

III. WEIGHT AND DIET HISTORY

1. Birth Weight (if known):

2. Why do you want to lose weight?

3. When did you first notice you had a weight problem?

4. Can you recall any specific circumstances associated with the onset of a considerable gain in weight?
(example: surgery, severe illness, accident, emotional trauma, etc). Please describe below:

5. What is your goal weight at this time?
Have you been at this weight before? When? How long?

6. Do you lose weight easily? If not, why?

7. PREVIOUS DIET HISTORY (fill in completely)

| Diet Description | Date Range | Weight Lost | Reason for stopping |
|------------------|------------|-------------|---------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

Which of the above methods was most successful for you? Why?

If you have regained your weight after any of your previous diets, why do you think you did?

8. Check this box if you have ever taken an appetite suppressant. If yes, Please specify below:

| <i>Drug Name</i> | <i>Year Taken</i> | <i>For how long?</i> | <i>Side effects or other remarks:</i> |
|------------------|-------------------|----------------------|---------------------------------------|
| | | | |
| | | | |
| | | | |

9. List all foods you avoid for health reasons:

10. Meal Habits:

How many meals do you prepare daily?
 How many meals do you eat daily?
 For how many persons do you cook?
 Number of meals eaten out weekly?
 Where?
 Which meal?
 How many snacks daily?

Is your weekend eating different from you weekdays? How?

How many cups/glasses/drinks of the following do you consume daily (leave blank for none):

Coffee (black)
 Coffee (sugar)
 Coffee (sugar and cream)
 Soft drinks (regular)
 Soft drinks (diet)
 Water
 Juice

Milk
 Tea
 Beer
 Wine
 Hard liquor
 Other (specify)
 Other (specify)

Do you consider your average meal size to be: (small, medium, large, extra large):

Do you usually eat: (click those that apply)

- Breakfast
- Lunch
- Snacks
- Second Helpings
- Dinner
- Standing up
- Other (specify-click box to right):

- Lying down
- While walking
- While working
- While cooking
- When driving
- Entertaining clients

Do you occasionally eat: (click those that apply)

- In the kitchen
- Living room
- Bedroom
- Den / family room
- Dining room
- Patio
- Other (specify to rt):

- Watching TV
- Listening to the stereo
- Reading
- When not hungry
- When bored
- When you open the refrigerator

11. Exercise Habits

Please describe your exercise habits in the box below. If none, write 'None'.

Check here if exercise has been included in your previous weight reduction programs.

12. Check here if being overweight bothers you. Explain why below.

13. How does your family (or friends) feel about your appearance?

14. Do emotional problems make you: (click on all that apply)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Tense | <input type="checkbox"/> Use more alcohol |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Smoke more |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Lose appetite |
| <input type="checkbox"/> Sleepless | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Overeat | |

15. Which of the following do you feel contributes to your weight problem?

(click on all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Getting older | <input type="checkbox"/> Lack of nutritional knowledge | <input type="checkbox"/> Eating out too frequently |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> No control over food served to me | <input type="checkbox"/> History of abuse |
| <input type="checkbox"/> Moving to new climate | <input type="checkbox"/> Ethnic food habits | <input type="checkbox"/> Eating left-overs when cleaning table |
| <input type="checkbox"/> Always clean the plate | <input type="checkbox"/> Holiday events | <input type="checkbox"/> Eating at sports events |
| <input type="checkbox"/> Eat too fast | <input type="checkbox"/> Abnormal metabolism | <input type="checkbox"/> Eating in movie theater |
| <input type="checkbox"/> Eat oversized portions | <input type="checkbox"/> Other medical problems | <input type="checkbox"/> Eating to reward myself for something |
| <input type="checkbox"/> Eat too many sweets | <input type="checkbox"/> Childhood neglect | <input type="checkbox"/> Overeat to get attention |
| <input type="checkbox"/> Change / quit / lose job | <input type="checkbox"/> Food makes me feel good | <input type="checkbox"/> Compulsive overeater with no control |
| <input type="checkbox"/> Family discord (mate, kids, etc) | <input type="checkbox"/> Have to work with food on my job | <input type="checkbox"/> Entertaining customers at work |
| <input type="checkbox"/> Getting married | <input type="checkbox"/> Sampling food while putting away after shopping | <input type="checkbox"/> Not enough exercise |
| <input type="checkbox"/> Getting divorced | <input type="checkbox"/> Eating while watching TV | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Emotional trauma | <input type="checkbox"/> Unable to tell when I'm full until I feel miserable | <input type="checkbox"/> Skip meals, then overeat |
| <input type="checkbox"/> Out-of-control eating | <input type="checkbox"/> Eating takes my mind off problems | <input type="checkbox"/> Tasting while cooking |
| <input type="checkbox"/> Social obligations and events | <input type="checkbox"/> Overeating to maintain strength / power / health | <input type="checkbox"/> Eat between meals |
| <input type="checkbox"/> Other medications | <input type="checkbox"/> Eating when alone | <input type="checkbox"/> Other (Specify below): |
| <input type="checkbox"/> Serving food at parties | <input type="checkbox"/> Purging behavior | |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Bad eating habits | |
| <input type="checkbox"/> Home meal preparation | <input type="checkbox"/> Don't stop eating until everyone else is finished | |
| <input type="checkbox"/> Traumatic life event | <input type="checkbox"/> Do not eat regular meals but usually eat on the run | |

THANK YOU!