# HEALTH HISTORY QUESTIONNAIRE

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

Date:

Name: (First) Date of Birth: Referred by:

(MI)

(Last)

# FAMILY WEIGHT HISTORY AND HEALTH BEHAVIORS

* 1. Do you have a family history of higher weight?

□ Yes □ No

* 1. What family members have struggled with their weight?

□ Grandparents □ Father □ Mother □ Brother □ Sister

* 1. Was food always available growing up in your home?

□ Yes □ No

* 1. What was your family's approach to cooking, eating, and meals as a child?

# WEIGHT RELATED MEDICAL CONDITIONS

* 1. How is weight impacting your health?
     + Diabetes/Prediabetes
     + Fatty Liver Disease
     + PCOS
     + High Blood Pressure
     + Heart Failure
     + High Cholesterol
     + Heart Disease
     + Abnormal Heart Rhythm
     + Blood Clots
     + Others
* Sleep Apnea
* Asthma
* Arthritis/Joint Pain
* Skin problems
  + Heartburn
  + Depression
  + Anxiety
  + Fatigue

# WEIGHT HISTORY AND HEALTH BEHAVIORS

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

□ Childhood □ Teens □ Adulthood □ Pregnancy □ Menopause

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

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

* + - Other
  1. What was your weight one year ago? Two years ago? Five years ago?
  2. What has been your highest weight?
  3. What was your weight around age 20?
  4. 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
     + LA Weight Loss
     + Zone diet
     + Paleo diet
     + Ornish diet
     + Nutrisystem
     + Atkins
     + Medifast
     + HCG Diet
     + Other:
     + Jenny Craig
     + South Beach
     + Dash Diet
     + Mediterranean diet
  5. Have you ever used any prescription medications for weight loss? Check all that apply.
     + Phentermine (Adipex)
     + Phendimetrazine (Bontril)
     + Bupropion (Wellbutrin)
     + Other (including supplements)
     + Meridia
     + Topamax
     + Belviq
     + Xenecal/Alli
     + Saxenda
     + Qysmia
     + Phen/Fen
     + Diethylpripion
     + Belviq

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

* 1. How is your weight affecting your health and your life?
  2. What do you consider some of your barriers when it comes to managing your weight? Check all that apply.
     + Hunger
     + Time
     + Cravings
     + Knowledge
     + Fatigue
     + Others
     + Finances
  3. 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

* 1. Are you currently following a particular eating plan? □ Yes □ No If yes, which one?
     + Low fat
     + Vegan
     + Low carb
     + Other
     + Keto □ Mediterranean
  2. Have you tried particular eating plans or diets in the past? □ Yes □ No

If yes, which ones have you tried, and which ones worked or did not work for you?

* 1. Number of meals and snacks you eat on an average day:

□ 3 □ 3 - 5 □ 6 - 8 □ 8 - 10+

* 1. Food allergies/intolerance. Check all that apply.

□ Gluten □ Dairy □ Tree Nuts □ Eggs □ Soy □ Fish/Shellfish

* + - Other
  1. Who does the most cooking and/or grocery shopping at your house?

□ Self □ Spouse/Partner □ Other member of household □ Other

* 1. Food preferences including ethical or cultural considerations:
  2. 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

* 1. Triggers for eating. Check all that apply.
     + Hunger
     + Time of day
     + Stress
     + Other
     + Boredom □ Cravings
  2. Barriers to eating healthy. Check all that apply.
     + Cooking Skills
     + Time
     + Financial reasons □ Access to healthy foods
     + Schedule
     + Homework/Circumstances
     + Other
  3. 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

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

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

* 1. Types of activities you participate in regularly. Check all that apply.

□ Walking □ Biking □ Strength training □ Yoga

* + - Other

# ALCOHOL

* 1. Do you drink alcohol?

□ Yes □ No If yes, what kind? Check all that apply.

□ Beer □ Wine □ Liquor □ Cocktails

* 1. How many drinks per week do you drink?

□ None □ 1 - 3 □ 4 - 7 □ More than 8

* 1. Are you concerned about the amount your drink?

□ Yes □ No

# SMOKING

* 1. Do you or have you ever smoked tobacco? □ Yes □ No
  2. How has tobacco use or changes in tobacco use influenced your weight?

# CALORIC BEVERAGES

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

□ Yes □ No If yes, what kind/kinds

How many ounces per day of average?

# SLEEP

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

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

* 1. Do you work a nightshift or shiftwork? □ Yes □ No
  2. Usual bedtime: Usual waking time:
  3. Do you have trouble falling asleep or staying asleep? □ Yes □ No
  4. 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?

* 1. Do you snore? □ Yes □ No
  2. Are you tired throughout the day? □ Yes □ No
  3. Has anyone observed that you stop breathing during sleep? □ Yes □ No
  4. Do you often wake up with headaches in the morning? □ Yes □ No
  5. 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:

* 1. Do you feel like you have healthy coping mechanisms for stress? □ Yes □ No How do you cope with your stress?
  2. Do you consider yourself an “emotional eater”? □ Yes □ No
  3. Do you ever feel depressed? □ Yes □ No
  4. Have you ever been diagnosed with a mental health condition? □ Yes □ No

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

* 1. Do you cry frequently? □ Yes □ No
  2. Have you ever attempted suicide? □ Yes □ No
  3. Have you ever seriously thought about hurting yourself? □ Yes □ No
  4. Have you ever been to a counselor or other mental health professional? □ Yes □ No If yes, are you currently receiving counseling?

# J. 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

# L. NUTRITION HISTORY

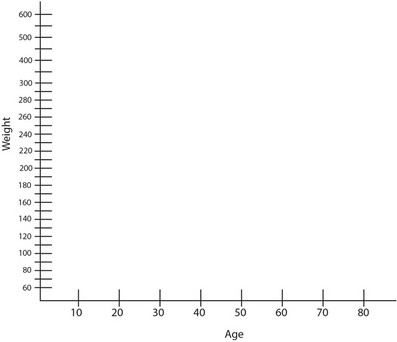
Please list your food and beverage intake for the past 24 hours.

|  |  |  |
| --- | --- | --- |
| TIME | FOOD AND BEVERAGES CONSUMED | PLACE CONSUMED |
|  |  |  |
|  |  |  |
|  |  |  |

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# M. WEIGHT GRAPH

Please chart your age and weight on the chart below.



# THE THREE FACTOR EATING QUESTIONNAIRE

Please read each statement and select from the multiple choice options the answer that indicates the frequency with which you find yourself feeling or experiencing what is being described in the statements below.

1. When I smell delicious food, I find it very difficult to keep from eating, even if I have just finished a meal.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. I deliberately take small helpings as a means of controlling my weight. Definitely true (4) mostly true (3) mostly false (2) definitely false (1)
2. When I feel anxious, I find myself eating.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. Sometimes when I start eating, I just can't seem to stop.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. Being with someone who is eating often makes me hungry enough to eat also. Definitely true (4) mostly true (3) mostly false (2) definitely false (1)
2. When I feel blue, I often overeat.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. When I see a real delicacy, I often get so hungry that I have to eat right away. Definitely true (4) mostly true (3) mostly false (2) definitely false (1)
2. I get so hungry that my stomach often seems like a bottomless pit.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. I am always hungry so it is hard for me to stop eating before I finish the food on my plate. Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

IO. When I feel lonely, I console myself by eating.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. I consciously hold back at meals in order not to weight gain.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. I do not eat some foods because they make me fat.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. I am always hungry enough to eat at any time.

Definitely true (4) mostly true (3) mostly false (2) definitely false (1)

1. How often do you feel hungry?

Only at meal times (1) sometimes between meals (2) often between meals (3) almost always (4)

1. How frequently do you avoid "stocking up" on tempting foods?

Almost never (1) seldom (2) moderately likely (3) almost always (4)

1. How likely are you to consciously eat less than you want?

Unlikely (1) slightly likely (2) moderately likely (3) very likely (4)

1. Do you go on eating binges though you are not hungry?

Never (1) rarely (2) sometimes (3) at least once a week (4)

1. On a scale of 1 to 8, where 1 means no restraint in eating (eating whatever you want, whenever you want it ) and 8 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?

.................. end ..................