WEIGHT MANAGEMENT PATIENT QUESTIONNAIRE

ABOUT YOU

Name (please print): _____ DOB: _____

Height: _____ Current Weight: _____ BMI (if known) _____

How long have you struggled with your weight? _____

Have you tried to manage your weight through diet and exercise? Yes ____ No_____

If yes, what diet and exercise changes have you made? And for how long? _____

_____

_____

Have you been in a structured weight loss program, such as Weight Watchers, Noom, etc?

Yes _____ If yes, which program(s)? _____

For how long? _____

No _____

What are your weight loss goals? _____

WEIGHT LOSS MEDICATIONS

Have you previously taken medication for weight loss? Yes _____ No_____

If yes, what medications have you tried? _____

_____

Did you have to discontinue any weight loss medications? Yes ____ No _____

If yes, why? _____