

**Weight History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M\_\_\_F \_\_\_ Age \_\_\_\_\_\_

What is your approximate weight? \_\_\_\_\_\_\_ pounds What is your height? \_\_\_\_\_\_ ft \_\_\_\_\_ inches

How old were you when you first became more than 20 pounds overweight? \_\_\_\_\_

What was your weight in high school? \_\_\_\_\_\_\_lbs Were you overweight as a child? Yes \_\_\_\_ No \_\_\_\_\_

What was the highest weight you have been in your life? \_\_\_\_\_ pounds

Have any of your close relatives been overweight or had obesity? Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ (check all that apply)

**Weight Management History**

Have you ever been treated by a doctor for your weight? If so, when? Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_ (yr)

Were you successful? Yes \_\_\_\_\_ No \_\_\_\_\_ How much weight did you lose? \_\_\_\_\_ lbs

Have you ever participated in a weight loss program? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate which of the following programs you have tried:

|  |  |  |  |
| --- | --- | --- | --- |
| **Program** | **Length of time** | **Weight Lost** | **When** |
| NutriSystem |  |  |  |
| Optavia |  |  |  |
| Weight Watchers |  |  |  |
| Other |  |  |  |
| Other |  |  |  |

**Have you ever taken medication to lose weight? Check all that apply**

Phentermine (e.g., Adipex) \_\_\_\_\_ Contrave (naltrexone/ bupropion) \_\_\_\_\_

Qsymia (phentermine/ topiramate) \_\_\_\_\_ Belviq (lorcaserin) \_\_\_\_\_

Saxenda (liraglutide for weight loss) \_\_\_\_\_ Xenical (prescription orlistat) \_\_\_\_\_

Alli (over the counter orlistat) \_\_\_\_\_ Topamax (topiramate) \_\_\_\_\_

Glucophage (metformin) \_\_\_\_\_ Ozempic (semaglutide) \_\_\_\_\_

Rybelsus (semaglutide) \_\_\_\_\_ Mounjaro (tirzepatide) \_\_\_\_\_

Wegovy (semaglutide) \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary Habits** Please describe your most common habits for each category. Enter 0 if you do not eat

that meal or snack.

|  |  |  |
| --- | --- | --- |
| **Meal/Snack** | **Time of Day** | **Place (home, restaurant, car, etc)/Typical Foods** |
| Breakfast |  |  |
| Morning Snack |  |  |
| Lunch |  |  |
| Afternoon Snack |  |  |
| Dinner |  |  |
| Evening Snack |  |  |
| Late Night Snack |  |  |
| Grazing |  |  |

**Physical Activity**

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If “yes,” what kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times per week? \_\_\_\_\_ How many minutes per session? \_\_\_\_\_

How many hours per day do you watch television? \_\_\_\_\_

What is your average screen time each week (social media, Kindle, etc)? \_\_\_\_\_

Do you work outside the home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you do housework? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Feelings About Eating and General Mood**

Do you feel distressed about episodes of overeating? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you often feel like you have no control over your eating or that you are unable to stop eating?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are you often embarrassed by how much you eat? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you frequently feel disgusted with yourself for overeating or do you feel guilty for overeating?

Yes \_\_\_\_\_ No \_\_\_\_\_

What are your weight loss goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think are barriers to reaching your goal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A picture containing text, font, letter, screenshot

Description automatically generated