MEDICAL WEIGHT LOSS HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:			
Name		Date	
Address			ZIP
Phone ( )			
Email		ok to contact by email ☐ Yes ☐ No	
Height	Weight	DOB	Age
Emergency Contact Name:			Phone ( )

SURGERY	DATE
1.	
2.	
3.	
4.	

DRUG ALLERGIES and Reaction
1.
2
3.

MEDICATIONS: (All medication including aspirin or vitamin supplements)	DOSAGE	Frequency

NUTRTIONAL EVALUATON

1. Maximum weight?____________________ Minimum weight? _______________________
2. Weight at 21 years old.____________________ Desired weight? ____________________
3. When did you begin gaining weight?____
4. What restaurants do you frequent? ____
5. How often do you frequent fast food restaurants? ____
6. Who shops for groceries? ____
7. Do you have a shopping list?____
8. Who plans meals?____
9. How often do you eat out? ____
10. Do you drink soda, caffeine? ____
11. Do you eat under stressful situations? ____
12. Is your partner overweight? ____
13. What are your worse food habits? ____
14. How many hours do you sleep at night? ____
15. Do you awaken at night hungry? ____

16. Do you use sugar substitutes? ____
17. Snack habits? ____
18. Foods you crave?____
19. Foods you dislike? ____
20. Do you eat between meals? □ Yes □ No
21. Do you finish your meals before others? □ Yes □ No
22. Is quantity of food more important than quality? □ Yes □ No
23. Do you love high fat or high sugar foods? □ Yes □ No
24. Do you often do other activities while eating? □ Yes □ No
25. Do you eat large portions? □ Yes □ No

Typical	Breakfast	Lunch	Dinner
When?			
Where?			
What?			

Circle the level of stress you are experiencing on a scale of 1to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (eg work, finances, relationship(s) etc) ______________________________
What is your overall energy level on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Do you sleep through the night? Y □N Do you wake rested? □ Y □N
Do you consider yourself: □ underweight □ overweight □ just right
Have you had unintentional weight loss or gain of 10 pounds or more in the last three months? □ Y □N
What is your nutrition and diet like? □Mixed food diet (animal and vegetable source) □Vegetarian □Vegan
What are your eating habits? □ One meal per day □Two meals per day □Three meals per day □Graze (small frequent meals) □Eat constantly whether hungry or not □Caffeine (coffee, pop, etc) □ Laxative use
Glasses of water/day____ Cups of coffee per day _____ Energy Drinks (Monsters/RedBull) per day______
Exercise history: □None □1 to 2 days per week □ 3 to 4 days per week □ 5 to7 days per week
□Less than 45 minutes per workout □ More than 45 minutes per workout
How committed are you to making a change in your health (1=least, 10=most committed):1 2 3 4 5 6 7 8 9 10
Do you tend to be sensitive to medications? □ Y □N
Are you particularly sensitive to perfumes, gasolines, or other vapors? □ Y □N
Do you use pesticides, herbicides or other chemical around you home? □ Y □N

PAST HEALTH HISTORY

Have you been diagnosed with □ Cancer □ High Blood Pressure □ Diabetes Kidney disorder □ Liver disorder
Any major accidents?□ Y □N What year: ____________
Any fractures? ?□ Y □N What location______________ What year: ____________
Have you had any imaging □ X-rays □ MRI □ CT □ Ultra Sound □ LABs results: □ Normal or □Abnormal
When was you last blood work? ________________
Any seizure history? □ Y □N □Antacids □Steroids □Hormone Replacement therapy
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? □ Y □N