PINNACLEHEALTH
Weight Loss Center

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PATIENT QUESTIONNAIRE

NAME:______________________________________ DATE COMPLETED:______________________

Medical History
Do you have any of the following medical conditions: (Currently or in the past)

Cardiovascular
- ☐ Coronary Artery Disease/Angina
- ☐ Heart Rhythm Abnormalities
- ☐ Heart Valve Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease

Gastrointestinal
- ☐ Gastroesophageal Reflux
- ☐ Peptic Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)
- ☐ Lactose Intolerance
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Liver Disease

Musculoskeletal
- ☐ Arthritis
- ☐ Back
- ☐ Hips
- ☐ Knees
- ☐ Gout
- ☐ Herniated Disc

Metabolic
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ High Triglycerides
- ☐ Metabolic Syndrome
- ☐ Osteoporosis

Genitourinary
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Stress Incontinence

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Post Traumatic Stress Disorder
- ☐ Other__________________

Respiratory
- ☐ Sleep Apnea
- ☐ Asthma or COPD

Reproductive
- ☐ Infertility
- ☐ Abnormal Menses
- ☐ Polycystic Ovary Disease

Blood/Immune System
- ☐ Anemia
- ☐ Lupus
- ☐ Bleeding Disorders
- ☐ Immune Disorders
- ☐ Cancer
  Type__________________

Surgical History
List all surgeries you have had:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Prescription Medications:

Name of Medication	Dosage Strength	How often med is taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

Form 0659-20 (11/14) InD

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Allergies

List all you have had:

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Over the Counter Meds/Vitamins/Herbs/Nutritional Supplements/Diet Aids

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Family Medical History:

Family Member	Present Age	Age at Death	Medical Problem(s)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Sibling			

Social History

Substance use: ☐ YES ☐ NO

If yes: How many packs per day? ________ How long have your smoked? ____________________

If no: Have you smoked in the past? ☐ YES ☐ NO If yes, how long?____________________

Do you drink alcohol? ☐ YES ☐ NO

If yes: What type of alcohol do you drink? ____________________

How often? ________ How much at one time? ____________________

Caffeine use: How much of the following beverages do you drink daily?

Coffee__________ Diet Soda__________

Tea__________ Regular Soda__________

Occupation:

What is your occupation? ____________________

Would you describe your job activity as?

☐ Sedentary ☐ Light Activity ☐ Moderate Activity ☐ Heavy Activity

How long is your transit time to work each way? ____________________

Does your job require overnight travel? ☐ YES ☐ NO

Do you enjoy your job? ____________________

Family:

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Number and ages of children:____________________

Name:____________________

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Current Weight _____________lbs and Height _______ft.______in. BMI____________

Weight History

Which of the following family members have/had weight control problems?

☐ Mother ☐ Brother of Sister ☐ Paternal Grandparents
☐ Father ☐ Maternal Grandparents ☐ Children

Where you an overweight child? ☐ YES ☐ NO

How long do you feel that your weight has been a problem? ____

List your approximate weight at the following times:

High School Graduation______________ lbs
At marriage ________________________ lbs
At birth of your first child _____________ lbs
(both men & women)

5 years ago___________________________ lbs
1 year ago ___________________________ lbs
Minimum weight as an adult______________ lbs
Maximum weight as an adult _____________ lbs

List any medical problems, injuries, or life events that have significantly affected your weight.
Include year and weight change.

1. ____
2. ____
3. ____
4. ____

Diet History:
List of Diets Attempted

Name of Diet	Year(s) Attempted	Length of Diet	Amount Lost
Physician Supervised			
Dietitian Supervised			
Weight Watchers			
LA Weightloss			
Jenny Craig			
Diet Workshop			
Nutrisystem			
Medifast/Optifast			
TOPS			
Overeater's Anonymous			
Richard Simmons			
Atkins Diet			
Carb Addict's			
Self Directed			
Other:			
Other:			
Other:			

List any medication or diet aids you have tried for the purpose of losing weight:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____

In your opinion, what contributes to your excess weight?

☐ Portion sizes ☐ Compulsive eating ☐ Portion sizes ☐ Lack of exercise ☐ Eating too much fat & sugar
☐ Nervous eating ☐ Emotional eating ☐ Stress

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Current Dietary Habits

Would you rate your current diet and eating habits as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Would you rate your current nutrition knowledge as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Would you describe your appetite as: ☐ Hearty ☐ Moderate ☐ Poor

Food preferences

Are there foods you cannot eat? ☐ YES ☐ NO
If yes, what foods? ______
What happens when you eat this food? ______
Which foods do you have a strong dislike for? ______
Are there any strong religious or cultural influences on your eating habits? ☐ YES ☐ NO
If yes, how do they affect your eating habits or diet?
______

Portion Sizes/Servings

Size of meat, poultry or fish serving ______ oz.
Number of meat, poultry, or fish per day ______
Number of eggs per week ______
Servings of fruit per day ______
Servings of vegetables per day ______
Type of dairy products used ☐ High Fat ☐ Low Fat ☐ Non Fat
Type of bread eaten ______
Glasses of water per day ______

Eating Habits

How many meals a day do you eat? ______ How long does it take to eat a meal? ______
Do you skip meals? ☐ YES ☐ NO
Do you snack? ☐ YES ☐ NO
If yes, what do you eat? ______
Do you eat immediately after arriving home from work or school? ☐ YES ☐ NO
Do you eat while watching television? ☐ YES ☐ NO
Where in the house do you eat? ______
What other activities do you do while eating? ______
How many meals each week are eaten at: Home?______ Work?______
School?______ Restaurants?______
Do you pack a lunch for work or eat out? ______
When dining out: Do you attempt to order nutritionally healthy meals? ☐ YES ☐ NO
Are you comfortable asking for special requests? ☐ YES ☐ NO
How is the food usually prepared? ☐ baked ☐ broiled ☐ fried
Is oil, butter or margarine used regularly for cooking? ☐ YES ☐ NO
Is salt routinely added to foods? ☐ YES ☐ NO
Are sauces used regularly? ☐ YES ☐ NO

Psychological/Support

Have you ever been diagnosed with a psychiatric condition? ☐ YES ☐ NO
Have you ever been hospitalized for a psychiatric condition? ☐ YES ☐ NO
Have you ever been sexually abused? ☐ YES ☐ NO

Do you or have you ever had a history of:

☐ Binge eating ☐ Laxative use to control weight ☐ Compulsive eating
☐ Bulimia - binge eating followed by self-induced vomiting ☐ Self-induced vomiting

Why do you eat? (check all that apply)

☐ hunger ☐ boredom ☐ stress ☐ guilt ☐ enjoy taste ☐ depression ☐ anger ☐ control

Which of the following are major stresses in your life? (check all that apply)

☐ job ☐ children ☐ lack of available time ☐ running household ☐ spouse ☐ medical problems

Name: ______

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Psychological/Support - Continued

Have you ever had psychological counseling for weight management? ☐ YES ☐ NO
How would you rate your self-esteem? ☐ High ☐ Fair ☐ Low

Binge Eating: (check all that apply to you)

☐ I have episodes of eating an amount of food definitely larger than most people would eat in a two hour period.
☐ I have a sense of lack of control over eating during this episode.

During a binge eating episode, I: (check all that apply to you)

☐ eat much more rapidly than normal.
☐ eat until I feel uncomfortably full.
☐ eat large amounts of food when not feeling physically hungry.
☐ eat alone because of embarrassment.
☐ eat until I feel uncomfortably full.
☐ feel disgusted with myself, depressed or very guilty afterwards.

How many days a week do you binge eat? ____________________

How do you feel that losing excessive weight will affect your life in the following ways?

Medical changes:____________________
Physical changes: ____________________
Self-esteem changes: ____________________
Occupational changes: ____________________
Relationship changes: ____________________

Goals:

What are your goals in the following areas?

	Amount of weight lost	Fitness/Health goals
In one month	____________	____________
3 months	____________	____________
6 months	____________	____________
1 year	____________	____________
Target Weight	____________	____________

Do you feel you will be able to perform the work and have the dedication to achieve these goals? ☐ YES ☐ NO

Comments and concerns

Please write any concerns, questions or comments you have relating to this questionnaire, or any concerns about participating in a weight management program.

____
____
____
____
____
____
____
____
____

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Quality of Life
Describe how you feel your excess weight is affecting the following aspects of your life:

Daily activities you cannot perform ______________________________
Ability to exercise______________________________
Affect on pain______________________________
Affect on ability to perform job duties ______________________________
Social activities you cannot perform ______________________________
Affect on your marriage/romantic relationship______________________________
Affect on relationship with children ______________________________
Affect on self esteem______________________________

Sleep Apnea

Have you ever been tested for sleep apnea?	☐ YES	☐ NO
Do you snore?	☐ YES	☐ NO
Do you ever wake up at night gasping for air?	☐ YES	☐ NO
Has anyone told you that you that you stop breathing while asleep?	☐ YES	☐ NO
Is it hard to fall asleep?	☐ YES	☐ NO
Is it hard to stay asleep?	☐ YES	☐ NO
Do you wake up tired?	☐ YES	☐ NO
Do you wake up with a headache?	☐ YES	☐ NO
Do you feel you are excessively sleepy during the day?	☐ YES	☐ NO
Do you fall asleep at work?	☐ YES	☐ NO
Do you have difficulty staying awake while driving?	☐ YES	☐ NO
Do you have difficulty staying awake while watching TV?	☐ YES	☐ NO

Gastroesophageal Reflux Disease

Do you frequently suffer from heartburn or indigestion?	☐ YES	☐ NO
Do you frequently us antacids?	☐ YES	☐ NO
Have you ever had an Upper GI or Endoscopy?	☐ YES	☐ NO
Do you wake up at night with indigestion?	☐ YES	☐ NO

Urinary Stress Incontinence

Do you leak urine when you cough, sneeze or laugh?	☐ YES	☐ NO
Do you wear a pad to prevent urine from wetting clothes?	☐ YES	☐ NO

Exercise History

Do you exercise regularly? ☐ YES ☐ NO
If yes, describe type and frequency______________________________
If no, why?______________________________
What factors interfere with exercising?
☐ Time ☐ Convenience ☐ Medical ☐ Motivation
What type of exercise do you enjoy?______________________________
What type of exercise do you dislike?______________________________
At what time of day do you prefer to exercise? ______________________________
Do you enjoy exercising alone or in a group? ______________________________
Do you have any physical limitations or injuries that prevent certain types of exercise? ☐ YES ☐ NO
If yes, what are they and how do they affect you?
____

Name:______________________________