Medical Program Diet History and Lifestyle Questionnaire

CONFIDENTIAL **Date:** _____

NOTE: This form must be completed before you can be enrolled in the Medical Weight Management Program. Please answer every question. Please print, type or write clearly.

Name (Last-First-Initial)_____

Address (Street-City-State-Zip) _____

Daytime Phone No._____ Evening Phone No. _____

Occupation _____

Name of Employer _____

Birth date (Month-Day-Year)_____

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

Sex: ☐ Male ☐ Female

Weight History

Patient weight (lbs) _____

Indicate ages during which you were overweight:

☐ Childhood (Age 2-11 yrs) ☐ Age 20-29 yrs ☐ Adolescence (Age 12-19 yrs) ☐ Age 30-40 yrs ☐ Over 40 yrs

Present height (feet, inches) _____

What is your goal weight? _____

When did you last weight this amount? _____

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (eg. NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.):

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment?
Sample: Weight Watchers	*2 months*	*Desired other foods*	*Dizziness*

Which weight loss method do you consider your most successful? _____

What accounted for that success? _____

_____