Remember to bring completed **Questionnaire** to your *Initial Consultation*

ROSEBUD PHYSICIANS WEIGHT LOSS PROGRAM

INTAKE QUESTIONNAIRE

No one likes questionnaires, but we invite you to consider this one as exceedingly important. It enables us to analyze the complex causes of your overweight status. Please take the time to answer all questions completely.

Name_____ Date_____
Last First

Address_____ Home Ph. (___) ___-____
No. Street Apt

_____ Work Ph. (___) ___-____
City State Zip

Date of Birth__ /___/____ e-mail _____ Cell Ph. (___) ___-____

How were you referred to this office? _____

Who is your primary care provider? _____

List any other physician you see and for what problem:

_____ for _____

_____ for _____

_____ for _____

MEDICAL AND WEIGHT INFORMATION

What do you consider the state of your overall health?
□Good □Average □Below Average □Poor

Your weight at H.S. graduation____ Age 21____ Highest Weight ____Goal Weight____
Current Height_____ What is your target weight now? _____

Has your weight come on slowly (over years) or rapidly (a few months)? _____

At what **age** did you first start having a weight problem? _____

Why do you think you have gained weight? _____
_____

List your previous attempts to lose weight. Include which approaches helped and which did not.

_____

_____

What factors may have contributed to your regaining of weight? Please specify.

_____

_____

List any weight loss medications you have used in the past. Include whether prescription or non-prescription, which helped the most and the least. List how long you took it and about how much you lost.

Medication	Helped?	How long?	How much lost?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you used phen/fen (fenfluramine, dex-fenfluramine, Pondimin, or Redux), have you had an echocardiogram? _____If so, what were the results?_____

PAST MEDICAL HISTORY

Check any conditions you currently have or that you have had in the past:

□ Heart attack/angina
□ High blood pressure
□ Diabetes
□ Stroke
□ High cholesterol/ triglycerides
□ Arthritis
□ Gout
□ Epilepsy
□ Chronic fatigue syndrome
□ Gastro-esophageal Reflux
□ Fertility problems
□ Significant acne
□ Fibromyalgia
□ Drug abuse
□ Glaucoma
□ Headaches
□ Liver disease
□ Muscle weakness
□ Discolored lines on skin
□ Allergies
□ Easy bruising
□ Rheumatoid arthritis
□ Mood swings
□ Other joint problems
□ Thyroid disease
□ Kidney disease
□ Cancer, If so, what type?
□ Shortness of breath
□ Sleep apnea
□ Snoring
□ Poor sleep
□ Hard to fall asleep
□ Asthma
□ Arrhythmia
□ Depression
□ Bipolar disease
□ Heartburn
□ Osteoarthritis
□ Lupus
□ Constipation
□ Sleep apnea syndrome
_____

Women only:

□ Polycystic ovary disease
□ Excessive facial/body hair
□ Significant PMS
□ Infrequent/Irregular periods
□ Breast secretions
□ PCOS

Men only*:*

□ Enlarged Prostrate
□ Erectile Dysfunction

Surgical history: List any surgeries you have had:

_____

_____

Medications:
List any **medications** that you currently use:

_____ _____
_____ _____
_____ _____

List any other over-the-counter or herbal supplements you are currently taking:

_____ _____
_____ _____

List any medications that you are **allergic** to: _____

Smoking and Alcohol Use
Do you use tobacco products? □Yes □ No How much each day? _____ packs(s)
Do you use cannabis? □Yes □ No How often?_____
Do you use Hooka/ Vap? □Yes □ No How often?_____
How many beers, glasses of wine, or cocktails do you drink?
□ none □ 1-2 a month □1-2 a week □ 1-2 a day □ 3 or more a day

FAMILY HISTORY

Check any conditions affecting a **blood relative** (mother, father, sibling, child, aunt, uncle, grandparent). Please list who has or had the problem.

□ Heart attack _____ □ Under active thyroid _____ □ Stroke _____

□ Diabetes _____ □ High blood pressure _____ □ Gout _____

□ Depression _____ □ Alcohol abuse _____ □ High cholesterol _____

□ Obesity/overweight_____ □ Polycystic ovary disease _____

Exercise

Which best describes you? □ I used to exercise but haven't recently.
□ I have never really liked exercise / I have to struggle to get myself to exercise.
□ I am currently exercising on a regular basis.
If you do exercise, what exercise are you now doing on a regular basis?
_____ Hours per week? _____

When were you the most physically active as an adult? _____

What was your exercise pattern at that time? _____

What physical activity do you enjoy the most? _____

Have you had any specific injuries that limit your exercise activities? □ Yes □ No
If so, what? _____

Are there any health barriers to exercising right now? _____
If so, what? _____

Eating/Sleeping/Work Patterns

Which meals do you eat nearly every day? Give times and typical contents of that meal. If you usually skip the meal, indicate that.

□Breakfast _____

□Mid morning snack _____

□Lunch _____

□Mid-afternoon snack _____

□Dinner _____

□Evening snack_____

How many hours do you work per week? __How long is your commute to work? _____
When do you start and finish work each day?

Sunday _____
Monday_____ Thursday_____
Tuesday_____ Friday _____
Wednesday_____ Saturday_____

What type of work do you do?
_____
What time do you go to sleep? _____. What time do you usually get up? _____
How many hours do you sleep? ____.
Do you take naps? Are you sleepy during the day?
Do you snore? _____. Does it actually interrupt your sleep? _____

Are you likely to change jobs over the next 12 months? □ no □ maybe □ yes
Are you planning to move during the next 12 months? □ no □ maybe □ yes
Is there any serious or life-threatening illness in your immediate family? Who and what?
_____

Is there a particular time of day when you find it hardest to avoid overeating or to avoid eating "bad" food?_____ When is that?_____

Which foods do you find it hardest to resist? (Check all that apply)

□ candy □ alcoholic beverages □chocolate
□ ice cream/frozen treats □ soda pop – non diet □ cheese
□ cookies, cakes, muffins, etc. □ fats, chips, dressings, fried foods sauces
□ carbs: popcorn, bagels, bread, pasta, crackers, potatoes, corn, rice etc. Pizza
□ Sports drinks (Gatorade, Red Bull, 5-hour energy, Monster)
□ other _____

Do you have lactose intolerance? _____ □ yes □ no

Does milk (dairy products) upset your stomach, give you gas or cause diarrhea?
□ yes □ no
Is there a particular situation in which you are more likely to over eat even though **you're not really hungry?** What situation? _____

Are you most likely to reach for (circle all that apply to you):
salty foods fatty foods carbs/starchy foods sweets crunchy foods

Is the **amount of food (volume)** a problem? Do you go back for seconds? Are your portions large? □ yes □ no

Is there a food that really throws you off your diet plans? (A food that if you would stay away from completely, you would do far better with your eating?) □ yes □ no

Which food(s), if so?

_____
_____
_____

PSYCH-SOCIAL HISTORY
Thoughts about Food and Weight

Do you ever eat an unusually large amount of food in a short period?
□ no □ sometimes □ often

Do you feel out of control when you do so? □ no □ sometimes □ often

How many times per month could this happen? _____ # of times a month.

Do you eat food in secret or hide the fact that you're eating
□ no □ sometimes □ often

Do you use vomiting, laxatives or exercise to compensate for overeating?
□ no □ sometimes □ often

Do you eat when you feel stressed, nervous, angry, bored or down in spirit? □Yes □ No
How often? □ never □ sometimes □ often

Do you think you eat enough for you to weigh what you do? □ yes □ no

What will make it most difficult for you to stay on track?

_____
_____

How serious is your weight problem? **Circle the level that fits**

not serious at all 0-----1-----2-----3-----4-----5-----6----7-----8-----9-----10 very serious life threatening

What is the single largest factor that is motivating you to lose weight at this time?

_____

At this time, how important is it for you to lose weight and keep it off? Circle the level that fits

I want to lose weight 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 most important issue in my life
If it's not too hard

<u>If it means you will loose weight and keep it off, how willing are you to</u>:
Circle the level that fits for each activity

change your eating habits
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

shop for groceries
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

cook (and eat) at home
would resist doing this 0-----1-----2-----3-----4-----5-----6-----7----8----9----10 very willing to do

change your **exercise** habits
would resist doing this 0-----1-----2----3-----4-----5-----6-----7-----8----9-----10 very willing to do

rearrange your **schedule**
would resist doing this 0-----1----2-----3-----4-----5-----6-----7-----8-----9-----10 very willing to do

log food & exercise daily
would resist doing this 0-----1------2----3----4----5-----6-----7------8-----9-----10 very willing to do

<u>Social Issues</u>

Do you live alone or with others? _____

Are you in a relationship? □yes □no If so, what kind and how long?_____

Any significant strains or conflicts in that relationship, what are they?

_____

Do you have children? □Yes □ No Ages_____

Any special challenges with them? □Yes □ No If Yes, Explain:

_____

How would you rate the current level of stress in your life at this time? Circle a level

NO stress 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **Very high** stress

What is the greatest source of stress in your life right now, if any? _____

How do you handle stress/worry/anxiety currently?_____
Do you use food as a way to handle stress or to comfort yourself? □Yes □ No
How often do you do this? _____

If so, what do you say to yourself to justify this eating? (For example "It has been such a hard day, I deserve this treat…")

_____
_____

Do you have a support system in place to help you with this decision? □ no □ yes

Is there anyone who may sabotage you in your efforts to lose weight? □ no □ yes

How good of a time is this for you to be starting a weight loss program? Circle a level
Worst time 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Best **time**

Is there one thing that you could do that you know would make a large difference in your weight situation? What is it?

_____

Why do you think you don't make that change? _____

Spiritual Issues

Where are you spiritually? (That is, do you have a faith/religion?) □ yes □ no If yes, which one and how active are you in this faith (e.g. how often do you attend services/involved in activities?

_____

How do you see your purpose in life?

_____
_____

Who are you an example for? (e.g. "my child", "my younger brother") _____

What do you foresee as our role in helping you in your efforts to lose weight? Please write anything else you would like us to know. *Be creative. Feel free to add another page),*

_____

_____

_____