

Weight Control Questionnaire

James F. Day, M.D.
Medical Director
303.233.8400

Colorado Center for Weight Management



PHYSICIAN
REFERRAL CENTER
FOR THE
TREATMENT OF
OBESITY AND
RELATED
DISEASES

Please answer all questions. Do not leave any blank questions. If a question does not pertain to you, mark it NA (Not Applicable) and continue to the next question.

This questionnaire is to assist you in giving us information concerning your past weight history, previous dieting attempts, dietary habits, and needs for weight control. Please fill this questionnaire when you have plenty of time to do so. **DO NOT HURRY THROUGH IT.** Every question should be answered before you return this form to our office.

DO NOT leave any BLANK question! If a question does not pertain to you, mark it NA (Not Applicable) and go on to the next question. Answer all question to the best of your knowledge.

1. Name: _____
2. How did you hear about our program? _____
3. Private Family Physician: _____
4. What is your main reason for wishing to lose weight? _____

4. Birth weight (if known) _____ Length _____ Were you a heavy baby during the first six (6) months? _____
5. When did you first notice you had a weight problem? Age: _____ Year: _____
6. Can you recall any specific circumstances associated with the onset of a considerable gain in weight (e.g., surgery, severe illness, accident, emotional trauma, etc.)? Please describe: _____

If so, give pounds gained: _____ During how long a period of time? _____
Weight before: _____ Weight after: _____
7. During the past (3) months, have you gained? _____ Lost? _____
How much? _____ Reason: _____
If not, how long has your weight been stable? _____ What are you doing, if anything, to stay at this weight? _____

8. What do you think your "normal" weight is? _____ Have you ever been at your "normal" weight? _____ When? _____ For how long? _____
9. What is your weight goal at this time? _____ Have you been at this weight before? _____ When? _____ For how long? _____
10. Do you lose weight easily? _____ If the answer is NO, please indicated why you think you have difficulty: _____

11. Have you dieted before? _____ What is the most lost? _____ In what period of time? _____

PREVIOUS DIET HISTORY (Fill in completely)

Diet Description	Date Began and Weight	Age	Weight Lost	Date Ended and Weight	Reason for Discontinuing

With which of the above methods do you feel you had the most success? _____
 Why do you think it was successful? _____
 Do you usually regain lost weight? _____ How soon after the loss do you regain? _____
 Do you usually gain (circle one) more / equal / less weight than what was lost? If more, how much? ____
 If you have regained your weight after any of your previous diets, why do you think you did? _____

12. Have you ever taken any appetite suppressants? _____ If answer is YES, please give details:

Drug Name	Year Taken	For How Long?	List any side effects or other remarks

13. Are you currently taking water pills? _____ Drug Name: _____
 Dosage Strength: _____ Number per day: ____ When did you begin taking water pills? _____

14. Name any drugs you are currently taking:

Drug Name	Dosage Strength	Number Per Day	Time of Day	Remarks

Name any vitamins or supplements you are currently taking:

Vitamin or Supplement Name	Dosage Strength	Number Per Day	Time of Day	Remarks

15. List all foods you avoid for health reasons: _____

16. How many meals do you prepare daily? _____ How many meals do you eat daily? _____ For how many persons do you cook daily? _____

17. Number of meals eaten out weekly: _____ Where (type restaurant, friends, etc.)? _____

 Which meal? _____

18. How many snacks daily? _____

19. Describe how your weekend eating patterns differs from your weekdays eating patterns: _____

21. How many cups/glasses/drinks of the following do you consume daily:

Coffee (black) _____	Milk _____	Beer _____
Coffee (sugar) _____	Tea _____	Wine _____
Coffee (sugar & cream) _____	Water _____	Hard Liquor _____
Soft Drinks (regular) _____	Soft Drinks (sugar free) _____	

21. Do you consider your average meal size to be (circle one): small medium large extra large

22. Do you usually eat (circle all that apply): breakfast lunch dinner snacks second helpings

23. Do you regularly eat (check all that apply):

in the:

- ___ kitchen
- ___ living room
- ___ bedroom
- ___ den or family room
- ___ dining room
- ___ patio

while:

- ___ reading
- ___ lying down
- ___ walking
- ___ standing up
- ___ watching TV
- ___ cooking
- ___ not really hungry
- ___ bored
- ___ opening refrigerator door

- ___ driving
- ___ entertaining client
- ___ listening stereo
- ___ working

24. Do you exercise? _____ If yes, please give details:

Type of Exercise	Frequency	Duration	Alone or with a friend?

Has exercise been included in your previous weight reduction programs? _____

25. Does being overweight bother you? _____ If yes, explain how: _____

26. How does your family (or friends) feel about your appearance? _____

27. Do emotional problems make you (answer YES or NO):

Tense? _____ Nervous? _____ Sleepless? _____ Smoke More? _____
 Overeat? _____ Depressed? _____ Use More Alcohol? _____ Lose Appetite? _____

Other Effects (please explain): _____

28. Please **cross out** all reasons that **HAVE NOT** contributed to your weight gain:

- | | |
|--|---|
| Getting older | Abnormal metabolism or glandular disorders |
| Alcohol problems | Sexual problems |
| Moving to new climate, altitude | Can't afford proper food |
| Always clean plate | Stopped smoking |
| Eat to fast | Food makes me feel good |
| East oversized portions | Have to work with food on my job |
| Eat too many sweets and starchy foods | Sampling food while putting it away after shopping |
| Changing, quitting, or losing job | Eating while watching TV |
| Family discord (mate, children, relatives) | Unable to tell when I'm full until I feel miserable |
| Getting married | Eating takes my mind off problems |
| Getting divorced | Overeating to maintain strength, power, health |
| Care of home and children | Eating when alone |
| Birth control pills | Eating when bored |
| Social obligations and events | Bad eating habits |
| Other medications (specify) | Don't stop eating until everyone else is finished |
| Serving food at parties | Do not eat regular meals but usually eat on the run |
| Problems at work | Skip meals, then overeat |
| Home meal preparation | Tasting while cooking |
| No know reason for my weight problem | Eating between meals |
| Entertaining customers at work | Eating out too frequently |
| Not enough exercise | Eating when angry |
| Physical handicaps | Eating left-overs when cleaning off the table |
| Lack of nutritional knowledge | Eating at sports events or in movie theater |
| No control over preparation of food served to me | Eating to reward myself for achievements |
| Ethnic food habits | Overeat to get attention |
| Holiday events | Compulsive overeater with no control |
| Other medical problems (specify) | Other (specify) |

PATIENT INFORMATION

Today's Date _____ DATE OF BIRTH: _____

Mr./Mrs./Ms./Miss Last Name: _____ First _____ Middle _____

Address: _____ Apt. _____

City: _____ State: _____ Zip _____

Marital Status (circle one) Single Married Separated Divorced Age: _____ Sex (circle): Male Female

Social Security #: _____ Insurance Co. _____

Policy #: _____ Group #: _____ Education (years completed): _____

Occupation: _____ Employer: _____ Title/Degree: _____

Telephone: Home _____ Business _____

FAMILY HISTORY: For each family member below, follow the line across the page and mark an X in those boxes which indicated their present state of health (good), (poor), or their death (write in the cause), and any of the illnesses that thy have ever had. If married, print the names of your spouse and children in the spaces below.	Health			Cause of Death	Obesity	Allergies or Asthma	Anemia	Bleed Easily	Diabetes	Cancer or Tumor	Epilepsy	Glaucoma	Genetic Disease	Alcoholism	Kidney/Bladder trouble	Stomach/Duodenal Ulcer	Psychological Problems	Rheumatism or Arthritis	High Blood Pressure	Heart Trouble	Gout	
	Good	Poor	Deceased																			
Father:																						
Mother:																						
Brother or Sisters:																						
Spouse:																						
Child:																						
Child:																						
Child:																						
Child:																						
Child:																						
Child:																						
Paternal Relatives (write how many affected in each box)																						
Maternal Relatives (write how many affected in each box)																						
YOUR HEALTH HISTORY (mark with X for your illnesses)																						

Additional Illnesses or Problems: Circle any of the following you have now or have ever had.

- | | | | | | |
|-----------------|----------------|-----------------------|-------------------------|-----------------|----------------------|
| Eye infections | Emphysema | Hernia | Childhood hyperactivity | Measles | Mononucleosis |
| Thyroid disease | Pneumonia | hemorrhoids | Chicken pox | Mumps | Venereal Disease |
| Eczema | Pancreatitis | Neuralgia or neuritis | German measles | Polio | Yellow Jaundice |
| Hives or rashes | Liver disease | Tension/anxiety | Scarlet Fever | Rheumatic Fever | Other (Please List): |
| Bronchitis | Diverticulosis | Depression | | Malaria | |

Have you ever been turned down of life insurance, military service or employment because of health problems? YES NO

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. Check this box if you have had more than three such hospitalizations. Do not include normal pregnancies.

Hospitalization	Year	Operation or Illness	Name of Hospital	City and State
1st				
2nd				
3rd				

Tests and Immunizations: Mark an X next to those that you have had. Enter the year when you were given the test or immunization.

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> _____ chest x-ray | <input type="checkbox"/> _____ gallbladder x-ray | <input type="checkbox"/> _____ hepatitis | <input type="checkbox"/> _____ polio series | <input type="checkbox"/> _____ measles |
| <input type="checkbox"/> _____ kidney x-ray | <input type="checkbox"/> _____ electrocardopgram | <input type="checkbox"/> _____ smallpox | <input type="checkbox"/> _____ typhoid | <input type="checkbox"/> _____ mumps |
| <input type="checkbox"/> _____ G.I. series | <input type="checkbox"/> _____ TB test | <input type="checkbox"/> _____ tetanus | <input type="checkbox"/> _____ flue | <input type="checkbox"/> _____ pneumonia |
| <input type="checkbox"/> _____ colon x-ray | <input type="checkbox"/> _____ Other x-rays | | Injections | |

Medicines: Please list all medicines that your are sensitive or allergic to: