WEIGHT, HEALTH, AND LIFESTYLE QUESTIONNAIRE

All questions contained in this questionnaire are confidential and will become part of your medical record.
All questions are optional.

Today's Date: _____/_____/_____

Name: (First) _____ (MI} _____ (Last} _____

Date of Birth: _____/_____/_____

Ethnicity (Check all that apply): ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic White
☐ Other _____

Referred By: _____

Weight History

1. Have there been any circumstances or life events that have triggered weight gain for you?
   - ☐ Pregnancy ☐ Job Change ☐ New Medication ☐ Stress ☐ Boredom
   - ☐ Marriage ☐ Divorce ☐ Illness ☐ Injury ☐ Abuse
   - ☐ Alcohol ☐ Nightshift Work ☐ Travel ☐ Quitting Smoking
   - ☐ New Medication _____ ☐ Other _____
2. What was your weight one year ago? ___lbs Two years ago? ___lbs Five years ago? ___lbs ☐ Relatively the same
3. What has been your highest weight? ___lbs
4. What was your weight around age 20? ___lbs
5. During the past 6 months my weight has: Increased by ___lbs Decreased by ___lbs ☐ relatively the same
6. Have you lost weight with weight loss programs or diet plans in the past? If so, select from the list the program/method. (check all that apply):
   - ☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss
   - ☐ Atkins ☐ Keto diet ☐ South Beach ☐ Zone diet
   - ☐ Medifast ☐ Dash diet ☐ Paleo diet ☐ Mediterranean diet
   - ☐ Omish diest ☐ Intermittent Fasting ☐ Time restricted eating
   - ☐ Other: _____
7. Have you ever used any prescription medications for weight loss? (check all that apply):
   - ☐ Phentermine (adipex) ☐ Meridia ☐ Xenecal/Ali ☐ Phen/Fen
   - ☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
   - ☐ Bupropion (Wellbutin) ☐ Belviq ☐ Qsymia ☐ Contrave
   - ☐ Wegovy ☐ Other (Including Supplements)
8. Have you ever had bariatric surgery? ☐ Yes ☐ No
   a. If yes, please list the procedure(s) and year(s). _____ _
   b. Are you currently interested in considering bariatric surgery? ☐ Yes ☐ No
   c. Have you ever consulted a surgeon regarding bariatric surgery? ☐ Yes ☐ No

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Diagnosed Conditions

Have you ever been diagnosed with any of the following? (please check all that apply)

- ☐ Hypertension (high blood pressure)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Diabetes (high blood sugar)
- ☐ Prediabetes/ Insulin Resistance
- ☐ Gestational Diabetes
- ☐ Infertility
- ☐ PCOS (Polycystic Ovarian Syndrome)
- ☐ Metabolic syndrome
- ☐ Fatty Liver disease
- ☐ Cirrhosis
- ☐ Lymphedema
- ☐ Lipidema
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart failure
- ☐ Pacemaker implanted
- ☐ Primary Pulmonary Hypertension
- ☐ Kidney Stones
- ☐ Thyroid disease
- ☐ Osteoarthritis
- ☐ Back Pain
- ☐ Acid Reflux
- ☐ Irritable Bowel syndrome
- ☐ Hernia
- ☐ Gallstones
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Eating disorder:
- ☐ Vitamin deficiency (please specify): _____
- ☐ Coronary artery disease
- ☐ Stroke
- ☐ Seizures
- ☐ Pancreatitis
- ☐ Medullar Thyroid Cancer
- ☐ Hyperthyroidism
- ☐ Chronic Kidney disease
- ☐ Autoimmune disorder
- ☐ Pseudotumor cerebri
- ☐ Cushing's syndrome
- ☐ Cancer: _____
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Lymphedema
- ☐ Sleep disorder
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Abnormal heart rhythm
- ☐ Heart valve disease
- ☐ Glaucoma
- ☐ MEN Type 2
- ☐ Other Medical Conditions: _____

Medications

List all the medications you currently take (including vitamins and supplements). Please indicate the dosage and frequency (number of times per day) of each medication.

Medication	Dosage	Frequency	Reason for Taking

Medication Allergies

Please list any medication allergies and your response:

_____

_____

Additional Information

Please use this space to provide any additional information that you think is important to understanding you or your weight problem, as well as the goals you seek.

_____

_____

_____