

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

DIETARY HISTORY

Please mark the types of food that you eat a lot:

 Carbs Fatty/fried foods Fast food Buffet restaurants Vegetables Fruits SnacksDo you keep a food diary? Yes No

If you count calories, how many calories per day? _____

Are you on meal replacements (shakes and bars)? Yes No

What triggers excessive eating for you?

 Stress Sadness Loneliness Boredom Watching TV Late night Binging Social

Tell us about your level of physical activity and exercise:

Activity Level (0-none, 10-very active): _____ Hours of exercise every week _____

What kind of activity? Walking Running Biking Water exercise Other _____What are **your own** reasons to lose weight?

1. _____
2. _____
3. _____

Mentally, where are you at this moment regarding weight loss plans?How **willing** are you? 0 1 2 3 4 5 (5 being most willing)How **ready** are you? 0 1 2 3 4 5 (5 being I am ready now)How **able** are you? 0 1 2 3 4 5 (5 being very able)**What is your stress level at present?**

On a scale of 0-10, I feel I am at _____ (0-not stressed, 10-very stressed)

Have you ever suffered from any of the following conditions? Glaucoma Seizures Thyrotoxicosis Panic attacks Problems with heart rhythm that required treatment Bulimia or anorexia nervosa Alcohol dependence Morphine dependence Other drug abuse problems**For female patients only:**Are you pregnant or planning to be pregnant soon? Yes NoAre you using effective birth control? Yes NoAre you breast feeding? Yes NoPlease check boxes for symptoms that are **recent** or **significantly** bothering you. Unexplained weight loss Fever Chills Fatigue Blurred vision Double vision/diplopia Eye pain Sinus problems Nose bleeds Ear ringing Hearing loss Mouth or tongue lesions Chest pain Irregular heart beats/palpitation Heart murmurs Leg pain Leg/foot ulcers Leg swelling Abdominal pain Nausea Vomiting Constipation Diarrhea Blood in stools Hernia Difficulty urinating Blood in urine Problems with bladder control Arthritis Joint pain and stiffness Gout Degenerative disc disease Low back pain Breast lumps Breast pain Nipple discharge Skin rashes Moles Dizziness Syncope/Fainting Seizures Headaches Weakness in arms or legs Tremors Tingling Anemia Bruising Lymph node enlargement/lumps in the axilla or groin Shortness of breath Chronic cough Wheezing Severe night sweats Excessive phlegm Depression Anxiety Panic attacks Memory problems