MED LIFE FIT
MEDICAL CLINIC & SPA

Patient Questionnaire

Date: ______________________ Date of Birth: _____/_______/_______

Patient Name: ____
Last First Middle Initial

Address: ____
House/Street Apt# City State ZIP

Phone (____) ________________ (_____) ________________ (_____) _________________
Home Cell Work

Current Occupation: ______________________________ Hours/Shift ____________________

General Patient Information

1. How did you hear about our Medically Supervised Weight Loss Program?
   - o Friend
   - o Bulletin/Advertisement
   - o Referred by Healthcare Professional

   If so, by whom _________________________________

2. Primary Care Physician:

   Name: ____

   Address: ____

   Phone: (_____) ____________ Fax: (_____) ______________

3. Do any of the following conditions run in your family?

Diabetes	Yes	No
High Blood Pressure	Yes	No
Heart Attack	Yes	No
High Blood Fats	Yes	No
(high cholesterol or triglycerides)		

4. Do any of the following family members have a history of overweight/obesity?

   Father Yes No

   Mother Yes No

   Number of sisters 0 1 2 3 4

   How many overweight __________

   Number of brothers 0 1 2 3 4

   How many overweight __________

Weight History

1. Your Current Height _____________

   Your Current Weight _____________

2. What has been your highest adult weight? (best estimate) ________________ Lbs.
3. What was your weight at age 18? (best estimate) ________________ Lbs.
4. What has been your lowest adult weight (not due to illness) that you have maintained for at least 1 year? ________________ Lbs. Maintained for __________ years.

   Was this weight achieved with weight loss effort? Yes No

5. What was your weight:

   6 months ago? ______________ Lbs

   1 year ago? ______________ Lbs

   2 years ago? ______________ Lbs

6. Were you overweight as a child? Yes No
7. Your goal weight: ______________ Lbs
8. Was there a time in your life you experienced a noticeable weight gain/loss? Yes No

If so, please record you age, weight at start of effort, pounds lost, and method used to lose the weight.

Age at time of Effort	Weight at Start of Effort	lbs. Lost	Method Used

9. In the past year, how many times have you started a weight loss program on your own that lasted:

   More than 3 days _________________ Less than 3 days _____________

10. If you have ever experienced any significant physical or emotional symptoms while trying to lose weight or after losing weight, please describe below:

Problem	Duration (weeks)	Type of Professional Help

11. Have you tried any of the following to lose weight in the past?
    a. Dietitian or Nutritionist Yes No
    b. Exercise Yes No
    c. Low Calorie Diet Yes No
    d. Very Low Calorie Diet Yes No
       (example – liquid, HMR, protein sparing, Optifast etc)
    e. Formal Group Diet Program Yes No
       (Weight Watchers, Overeaters Anonymous)
    f. Prescription diet drugs (please check all that apply) Yes No
       - Phentermine
       - Meridia
       - Xenical
       - Fenfluramine
       - Fen/Phen
       - Redux
    g. Over-the-counter diet drugs (example – Dexatrim) Yes No
    h. Psychological counseling/behavior modification Yes No
    i. Hypnosis Yes No
    j. Did you ever induce vomiting? Yes No
       If yes how frequently? ___________________
    k. Did you ever use laxative to help you lose weight? Yes No
       If yes how frequently? ___________________

12. Did you maintain your weight loss for at least 1 year after finishing the above methods?

    Yes No

13. Do any of the following apply to you?

    a. Do you eat when you are upset of nervous?

       Yes No

    b. Do you have a “sweet tooth” (i.e., eat a lot of candies, pastries, etc)?

       Yes No

    c. Do you tend to binge eat (i.e., eat very large amounts at one sitting)?

       Yes No

    d. Do you tend to wake up at night to eat?

       Yes No

Tobacco and Alcohol Use

1. Do you drink alcoholic beverages?
   - None
   - Less than 1 per week
   - 2-7 drinks per week
   - 8-14 drinks per week
   - 15-21 drinks per week
   - More than 22 drinks per week

2. Do you smoke cigarettes?

_____ Yes, Currently
- How many years have you been smoking? __________
- Number of Cigarettes per day?
  - Less than k
  - 5-14
  - 15-29
  - 30+

______ Former Smoker, when? _________________

______ Never

3. If you have ever had a problem with drugs or alcohol consumptions, please describe the problem and any help you have received.

____

____

____

____

____

Medical History

1. Please indicate whether you have any of the following medical problems:

a	Diabetes Mellitus	Yes	No
b	High blood pressure	Yes	No
c	High cholesterol	Yes	No
d	Angina (chest pain)	Yes	No
e	History of heart disease	Yes	No
f	History of stroke	Yes	No
g	Low back pain	Yes	No
h	Arthritis/Joint pain	Yes	No
i	Sleep Apnea (breathing or snoring problems at night)	Yes	No
j	Other breathing problems	Yes	No
k	History of ulcers	Yes	No
l	History of heartburn	Yes	No
m	Gallbladder disease/gallstones	Yes	No
n	History of liver disease	Yes	No
o	History of kidney problems/disease	Yes	No
p	History of cancer	Yes	No
q	Thyroid problems	Yes	No
r	Anemia or blood disorders	Yes	No
s	Mental disorder	Yes	No

2. Please specify if you have any other medical problems or a history of any other medical problems (please include dates)
   ____
   ____
   ____
   ____

3. Have you had any of the following surgical procedures?

a.	Surgery to produce weight loss	Yes	No
b.	Removal of gallbladder	Yes	No
c.	Removal of appendix	Yes	No
d.	Surgery on the stomach, intestines, colon or other for weight loss	Yes	No
e.	Surgery on the uterus, ovaries, or fallopian tubes	Yes	No

   If so, what type? ____________________________________

4. For Women: Please indicate whether you have had the following:
   a. Loss of control of urination Yes No
   b. Menstrual irregularity Yes No
   c. Infertility Yes No
   d. Hirsutism (excessive hair growth) Yes No
   e. Gestational Diabetes Mellitus (diabetes during pregnancy) Yes No
   f. Gestational hypertension Yes No

5. Specify if you have a history of any other surgery:
____
____
____

6. Do you take anti-depressant medications? Yes No

7. Please list all the current **vitamins, herbal products, etc**. that you are currently taking:
____
____
____

8. Please list all current **medications with doses and frequency:**

Medication	Dose	Frequency

9. Please list all allergies or intolerances (i.e. lactose):

Medications:
____
____
____

Foods:
____
____
____

Other:
____
____
____

10. If you have diabetes, please check all that apply:

a. Check blood sugar daily Yes No
b. Seen a diabetes nurse educator for diabetes Yes No
c. Seen a dietician for your diabetes Yes No

Eating Patterns Section I

1. Please pick the number that best describes how much the behavior influences your weight gain:

   1 Does not contribute
   2 Contributes a small amount
   3 Contributes a moderate amount
   4 Contributes a large amount
   5 Contributes the greatest amount

   a. _____ Eating too much food
   b. _____ Overeating at breakfast
   c. _____ Overeating at lunch
   d. _____ Overeating at dinner
   e. _____ Snacking between meals
   f. _____ Snacking at night
   g. _____ Eating because I feel physically hungry
   h. _____ Eating because I crave certain foods
   i. _____ Eating because I cannot stop once I've begun
   j. _____ Continuing to eat because I don't feel full after a meal
   k. _____ Eating because of the good taste of food
   l. _____ Eating because of the sight and/or smell of food
   m. _____ Eating while cooking or preparing food
   n. _____ Eating when anxious
   o. _____ Eating when tired
   p. _____ Eating when bored
   q. _____ Eating when stressed
   r. _____ Eating when angry
   s. _____ Eating when depressed or upset
   t. _____ Eating when socializing
   u. _____ Eating when happy
   v. _____ Eating when alone

   Please indicate any other factors that you feel have contributed to your weight gain:

   ____
   ____
   ____
   ____

   How many days of the week do you eat the following meals? Write the number of days and the usual time of each meal in spaces below.

Meal	Days per Week	Time
Breakfast		
AM Snack		
Lunch		
Afternoon Snack		
Dinner		
PM Snack		

2. Who prepares the meals in your home?
____

3. Who does the grocery shopping?
____

4. List your favorite foods:
__________________ __________________ __________________
__________________ __________________ __________________
__________________ __________________ __________________

5. Please specify the amount (in 8 oz cups) of the following fluids you typically consume per day:

______ Skim milk
______ Low fat milk
______ Whole milk
______ Seltzer water
______ Fruit juice
______ Water
______ Coffee
______ Tea
______ Regular soda
______ Diet soda
______ Other; please list __________________

6. During a typical week, how many meals do you eat at a fast food restaurant (including drive-through and convenience stores)?

Breakfast _____________ meals a week
Lunch _____________ meals a week
Dinner _____________ meals a week

7. During a typical week, how many meals do you eat at a traditional restaurant, coffee shop, cafeteria, or similar establishment?

Breakfast _____________ meals a week
Lunch _____________ meals a week
Dinner _____________ meals a week

8. Please indicate the foods and liquids you consume on a typical **WEEK DAY** and **WEEKEND DAY**

WEEK DAY

Meal	Time	Location	Food/Beverage Consumed	Amount
Breakfast				
AM Snack				
Lunch				
Afternoon Snack				
Dinner				
PM Snack				

WEEKEND DAY

Meal	Time	Location	Food/Beverage Consumed	Amount
Breakfast				
AM Snack				
Lunch				
Afternoon Snack				
Dinner				
PM Snack				

Eating Patterns Section II

1. During the past 6 months, did you often eat an unusually large amount of food within a 2 hour period? Yes No

2. Did you usually have any of the following experiences during these occasions?

   a. Eating much more rapidly than usual Yes No
   b. Eating until you felt uncomfortably full Yes No
   c. Eating large amounts of food when you did not feel physically hungry? Yes No
   d. Eating alone because you are embarrassed by the amount of food you were eating? Yes No
   e. Feeling disgusted, depressed, or very guilty after overeating? Yes No
   f. Eating large amounts of food throughout the day with no planned meal times? Yes No

3. At the time that this episode started, how long had it been since you had previously finished eating a meal or a snack? ________ Hours ________ Minutes

4. Do you eat most of your meals:

   ______ Alone
   ______ With others
   ______ In front of TV or computer

5. During the last 3 months, did you ever fast (not eat anything) for at least 24 hours in order to avoid gaining weight? Yes No

   If yes, how often?

   ______ Less than once a week
   ______ Once a week
   ______ Two to three times a week
   ______ Four to five times a week
   ______ More than five times a week

Eating Patterns Section III

In reference to the past 6 months, please circle **ONE** answer for each question.

1. What level of appetite do you usually have in the morning?
    a. None
    b. Very little
    c. Little
    d. Moderate
    e. Large

2. How long after you get out of bed in the morning do you wiat to eat?
    a. 0 – 2 hours
    b. 2 ½ - 4 hours
    c. 4 ½ - 6 hours
    d. Over 6 hours

3. Do you snack in the middle of the night?
    a. Never
    b. Sometimes
    c. Half of the time
    d. Usually
    e. Always

4. How much of your daily food intake do you consume after supper?
    a. 0 – 25%
    b. 25 – 50%
    c. 50 – 75%
    d. 75 – 100%

5. How often do you have cravings to eat snacks after supper, but before bedtime?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Always

6. How often do you have cravings to eat snacks when you wake up at night?
    f. Never
    g. Rarely
    h. Sometimes
    i. Often
    j. Always

7. If you snack in the middle of the night, how aware are you of your eating?
   a. Not at all
   b. A little
   c. Somewhat
   d. Mostly
   e. Completely

8. How long has your current pattern of night eating been occurring?
   a. Never
   b. 1 – 3 months
   c. 3 – 6 months
   d. 6 – 12 months
   e. More than 1 year

Phsyical Activity

1. Please describe any physical problems that may limit your activity:
   ____
   ____
   ____
   ____
   ____
   ____
   ____

2. To what extent do you enjoy physical activity?
   ______ Not at all
   ______ Slightly
   ______ Moderately
   ______ Greatly

3. Please circle the types of physical activity you enjoy and have participated in during the past year.
   a. Walking (outdoors)
   b. Walking (indoors)
   c. Jogging
   d. Running
   e. Biking
   f. Aerobics
   g. Tennis/racket sports
   h. Swimming
   i. Basketball
   j. Golf
   k. Dancing
   l. Strength Training
   m. Other; please list _________________________

4. Please circle the values that best describe your consistent level of activity throughout the past 2 months in each category:

FREQUENCY

5	6 – 7 times per week
4	3 – 5 times per week
3	1 – 2 times per week
2	A few times per month
1	Less than once per month

INTENSITY

4	High aerobic activities that result in heavy breathing and sweating (i.e. high impact aerobics, running, speed swimming, distance cycling
3	Moderate aerobic activities (i.e. normal bike riding, jogging, low impact aerobics)
2	Light aerobic activities (i.e. volleyball, moderate speed walking)
1	Low aerobic activities (i.e. normal walking, golf)

DURATION

4	Over 30 minutes
3	20 – 30 minutes
2	10 – 20 minutes
1	Under 10 minutes

Family and Support Groups

1. What is your marital status?
   ______ Single
   ______ Married
   ______ Divorced
   ______ Separated
   ______ Widowed

2. What is your living situation?
   ______ Alone
   ______ with a spouse or partner
   ______ with significant other
   ______ with children
   ______ with parents/stepparents
   ______ with other relatives
   ______ with roommates

3. If you live with others, do they support your efforts to lose weight? Yes No

4. Do you have a person(s) who will support your weight loss efforts? Yes No

Psychological Factors

1. Have you ever had any problems with depression, anxiety, or other emotions that disrupted your normal functions? Yes No

   During the past month, have you felt sad or depressed much of the time? Yes No
2.
3. Pick the sentence that best describes your overall feelings about yourself:

   "In general, I am …"
   ______ very happy with who I am.
   ______ happy with who I am.
   ______ comfortable with who I am, but have some mixed feelings.
   ______ unhappy with who I am.
   ______ very unhappy with who I am.

4. Pick the sentence that best describes how you feel:

   "In comparison to most people, I think I have …"
   ______ very good self esteem.
   ______ good self esteem.
   ______ about average self esteem.
   ______ poor self esteem.
   ______ very poor self esteem.

5. Have you ever been subjected to physical abuse? Yes No

6. Have you ever been subjected to sexual abuse? Yes No

7. Please indicate if you are currently experiencing any stress in your life related to the following factors:

   a. Work
   b. Heath
   c. Relationship(s)
   d. Activities related to your children
   e. Activities related to your parents
   f. Legal/financial trouble
   g. School
   h. Moving
   i. Other; please list ________________________

   Please explain in a sentence any item to which you responded yes:
   ____
   ____
   ____

8. How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which 1 = "not motivated at all" and 10 = "extremely motivated"

   1 2 3 4 5 6 7 8 9 10

9. What has prompted you to lose weight at this time?
   ____
   ____
   ____
   ____
   ____
   ____

10. People who want to achieve long-term weight control need to spend at least 30 minutes each day, for a minimum of 6 months, trying to change their eating, exercising, and thinking habits. Which of the following sentences best describes you?

    ______ I definitely will not be able to devote 30 minutes daily for weight control
    ______ I'm not sure if I can find 30 minutes daily for weight control
    ______ I can definitely find 30 minutes daily for weight control
    ______ I can devote more than 30 minutes daily for weight control

11. Rate how confident you are that you will be able to significantly change your eating and exercising habits. Pick a number between 1 and 10, in which 1 = "not confident at all" and 10 = "extremely confident"

    1 2 3 4 5 6 7 8 9 10

12. Please use the space below to discuss any other information that you think is pertinent to your success in this weight loss program.

____

Disclaimer: In this practice it is important to know that Dr. Jessica Dowe and staff are Christians. Keep in mind that comments, concerns and advice may reflect this in conversations and are in no way intended to insult, offend or disrespect any patient. Likewise, the patient's own religious preference, if known, will be respected and patient care will not be compromised.