HEALTH TRANSITIONS CLINIC:

Initial history questionnaire:

Patient Name:____
DOB:_______________________ Age:_____________ Sex____________ Marital Status_________________
Occupation:____
Significant Other's Name____

PART 1: Weight, Diet and Exercise History

Obesity history: Current weight _____________and height________________
Goal weight: ______________________
Are you at your heaviest weight ever? ____________
If no when___________, what weight_________________

What prompted you to take action now?
Medical problems? ____
Doctor's advise? ____
Appearance? ____

What will you consider success? ____
____
____

Your Weight History:
At what age did you first consider yourself overweight? _______________________
Approximate weight at graduation from high school __________________________
Approximate weight (and age) at first marriage _______________________________ (age_________)
Lowest weight (and age) after first pregnancy__________________________________(age_________)
Lowest weight (and age) after last pregnancy__________________________________ (age_________)
Approximate weight at age 40 _______________________

Your Diet/Eating Behavior History:
How many meals per day do you eat? ____
Do you eat Breakfast? (Yes/No)
What do you commonly eat for breakfast? (Be as complete and specific as possible)
____
____
Number of meals per wk. prepared at home? ___________________________________ (Ave. week)
Number of meals per wk. at sit down restaurant? _______________________________ (Ave. week)
Number of meals per wk. at fast food restaurant? _______________________________ (Ave. week)
Number of meals per wk. eaten by yourself? ___________________________________ (Ave. week)

When you eat with others, do you have the perception that you eat more or less than others? More___________ Less_______________ About the same______________

Toward the end of a meal, do you typically start feeling full? (Yes/No)

Restaurant behavior:
Eat bread or chips before? Yes/No
Finish food on plate? Yes/No
Dessert? Usually/ Occasionally/ Infrequently / Never
Leave the restaurant feeling? Stuffed and uncomfortable /Satiated/ Still a little hungry

List 3 favorite entrees that you like to eat (home cooked, restaurant or fast food):

1. ____
2. ____
3. ____

In an average month, how often do you eat pizza? ______________________________
List 2 favorite side dishes that you like to eat:

1. ____
2. ____

In an average week, how often do you eat the following?
1. potatoes: _______________ 2. Pasta or noodles:_______________ 3. Rice:______________
4. corn: ______________ 5. Fruit:___________________

How many times do you snack per day? (Any food consumed other than at sit down meals)
____

In an average day, how often do you feel hungry? __________________________
How often do you eat when you are not hungry? ___________________________

List 3 favorite snack foods that you like to eat:

1. ____
2. ____
3. ____

Do you typically snack on foods that you don't necessarily like, crave or enjoy because you are hungry and feel compelled to eat something good for you?
List the common "good for you" snacks that you tend to eat:

1. ____
2. ____
3. ____

Liquid Consumption: What fluids containing calories do you consume? (PER WEEK)

Soft drinks (regular): ______________________________
Sports drinks: _____________________________________
Fruit Juices: _______________________________________
Vegetable Juices: __________________________________
Milk: ____
Protein shakes: _____________________________________

Your Current Exercise/Activity Pattern:

1. Estimate how much walking you do in an average day (both through your daily activity as well as any exercise):
   - Less than 5000 steps per day (2.5 miles)_________________
   - Between 5000-10,000 per day (2.5-5 miles) _____________
   - At least 10,000 steps daily (5 miles or more) _____________

(At an average pace, 5000 steps take approximately 40 minutes)

2. In an average week, how much time do you devote to exercise or recreational activities that involve physical activity. Please list:

____
____
____

3. How active is your job:
   - Mostly sitting __________________________
   - Moderate walking ______________________
   - Walking, climbing and lifting ___________

Previous Attempts at Weight Loss:

1. Formal programs? (Yes/No) e.g. Weight watchers, Jenny Craig, Optifast, Ideal Protein Please list name of program, approximate dates, and any initial success. Any idea in your mind why the program ultimately failed? (If more than 3, list most recent 3)

1. ____
   ____
2. ____
   ____
3. ____
   ____

2. Followed any diet books? (Yes/No)
Please list name of book, approximate dates, and any initial success. Any idea in your mind why the plan ultimately failed? (If more than 3, list any that led to even partial success)

1. ____
   ____
2. ____
   ____
3. ____
   ____

3. Any Physician supervised weight loss plans or medications? (Yes/No)

Fen-Phen ( )	Phentermine ( )	Meridia ( )	Xenical ( )
Topamax ( )	Qsymia ( )	Belviq ( )	Contrave ( )

Other Drugs ( ) ______________________________

4. Previous supervised exercise plan: (Yes/No). Approximate dates and any success?
____
____

Part 2: Medications and Obesity Associated Diseases

List all current medications, dose, and frequency:

Medication:	Dose:	Frequency:

1. Diabetes: (Yes/No)

Approximate date of diagnosis: ____

Most recent HbA1c and date: ____

Treated with: Diet alone__________

Medications_________ (all meds should be listed above)

Insulins______________ (all insulin and doses should be listed above)

Do you check blood sugars? How often in average week ____________

Do you change insulin dosing on a daily basis based on:

1. What you eat? (Yes/No)
2. Strict or estimated carbohydrate counting? (Yes/No)
3. What your pre-meal blood sugar is? (Yes/No)

Do you currently stick with a defined amount of carbohydrate per day (Yes/No)

If so, how much? ____

On a scale of 1-4 how compulsive are you in terms of measuring and sticking to the dietary limits? (1=very compulsive, 4=not at all)_______________

Are you aware of any diabetes related complications?

Heart disease (heart attack, bypass, stents, CAD) (yes/no)

Stroke (yes/no)

Kidney disease, proteinuria or microalbuminuria (yes/no)

Retinopathy (eye disease) (yes/no)

Neuropathy (pain in limbs or loss of sensation) (yes/no)

2. Sleep Apnea: (yes/no)

Do you wear CPAP or BiPAP? (Yes/no)

Ever have a sleep test? (Yes/no)

Have you been told that you snore loudly? (Yes/no)

Ever been told that you stop breathing at night? (Yes/no)

Do you struggle with daytime sleepiness? (Yes/no)

Ever fall asleep while driving? (Yes/no)

Do you have restless legs at night? (Yes/no)

Significant other threaten to sleep in another bed? (Yes/no)

3. Hypertension (high blood pressure): (yes/no)

Please make certain all current blood pressure medications are listed above.

Have you required several changes in BP medications? (Yes/no)

Do you monitor BP readings at home? (Yes/no)

Are your BP readings at the doctors usually acceptable? (Yes/no)

Any problems tolerating BP medications? (Yes/no)

Any problems with headaches? (Yes/no)

Any problems with lightheadedness? (Yes/no)

4. High cholesterol: (yes/no)

Are you taking medications for this? (Yes/no)
Have you been experiencing muscle pains since starting meds? (Yes/no)
Do you know how high your labs were before starting meds? (Yes/no)
Do you have a family history of heart disease (heart attack, bypass, stents, heart catheterizations or heart related chest pains)? (Yes/no)
Do you smoke, or have you smoked in past year? (Yes/no)

5. Musculoskeletal (arthritis and back pain): (yes/no)

Are you bothered by chronic back pain? (Yes/no)
Any previous operations on lower back or neck? (Yes/no)
Any epidural injections for back pain? (Yes/no)
Problems with chronic arthritis of knees, ankles or hips? (Yes/no)
Do you take medications for back pain or arthritis? (Yes/no)
Do you have Fibromyalgia? (Yes/no)
Do you have any chronic pain syndrome? (Yes/no)

6. Depression: (yes/no)

Have you struggled with depression? (Yes/no)
Have you been on several different medications over the years?(Yes/no)
Have you ever seen a psychiatrist? (Yes/no)
Currently seeing a psychiatrist? (Yes/no)
Have you ever seen a psychologist or counselor? (Yes/no)

7. Gastrointestinal problems: (yes/no)

Have you ever been told you had a fatty liver? (Yes/no)
Do you suffer from chronic reflux (heartburn)? (Yes/no)
Have you ever been told you had NASH (hepatitis)? (Yes/no)

8. Cancer: (yes/no)
Many forms of cancer have been strongly associated with overweight and obesity.
Have you ever been diagnosed with any form of cancer? (Yes/no)
If yes, please indicate type or location: ______________________________
Currently (active /remission)

9. Have any of your physicians advised you to lose weight? (Yes/no)
Please indicate physicians name and type of practice:

____ ___________________________
____ __________________________
____ __________________________
____ __________________________

Part 3: Family and Social History:

Family History:

Father alive/dead age________ cause of death____

Mother alive/dead age_______ cause of death____

Age of grandparents: indicate living (L) or dead (D) ____

____

Please indicate by circling which family member was affected, and stipulate relationship to other:

Diabetes	Mother	Father	other________________________________
Hypertension	Mother	Father	other________________________________
Heart Disease	Mother	Father	other________________________________
Obesity	Mother	Father	other________________________________
Sleep Apnea	Mother	Father	other________________________________
Early Death	Mother	Father	other________________________________
Cancer	Mother	Father	other________________________________

Social History:
Alcohol consumption per week____
Cigarette Smoking (Yes/No)
If yes, how many cig per day____
Number of years smoking ____
Last attempted quit ____

Who do you eat meals with ____
Do meal partners have weight problems ____