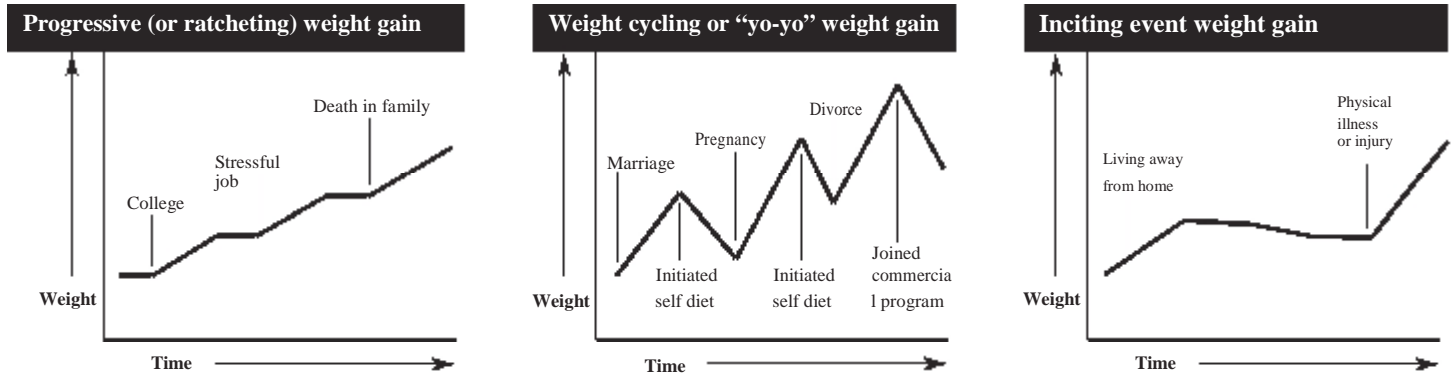


New Patient Comprehensive History

Part 1: Graphing Your Weight Gain

Patient name _____ Date _____

People gain weight in different ways — some gain in a progressive upward fashion, others gain in an up and down cyclical fashion, and others after a long period of controlled weight see their weight climb steadily after one inciting event. Commonly, though, most people can relate their changes in weight to different life events. See the examples below.



Please graph your own weight gain. Fill in the life events that you relate to your weight. Take note of your pattern so you can better understand your weight gain, that is, how you got to where you are at today. Thank you for taking the time to complete this chart.



Part 2: Weight Loss Questionnaire

Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

1. Is there a reason you are seeking treatment at this time?

2. What are your goals about weight control and management?

3. Your level of interest in losing weight is:

Not interested 1 2 3 4 5 Very interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

Not interested 1 2 3 4 5 Very interested

5. How much support can your family provide?

Not interested 1 2 3 4 5 Very interested

6. How much support can your friends provide?

Not interested 1 2 3 4 5 Very interested

7. What is the hardest part about managing your weight?

8. What do you believe will be of most help to assist you in losing weight?

9. How confident are you that you can lose weight at this time?

Not interested 1 2 3 4 5 Very interested

Weight history

10. As best as you can recall, what was your body weight at each of the following time points (if they apply)?

Grade school _____ High school _____ College _____ Ages 20-29 _____ 30-39 _____ 40-49 _____ 50-59 _____

11. What has been your lowest body weight as an adult? _____ What has been your heaviest body weight as an adult? _____

12. At what age did you start trying to lose weight? _____

13. Please check all previous programs you have tried in order to lose weight. Include dates and your length of participation.

Program	Date	Weight (lost or gained)	Length of participation
• TOPS	_____	_____	_____
• Weight Watchers	_____	_____	_____
• Overeaters Anonymous	_____	_____	_____
• Liquid diets (eg, Optifast)	_____	_____	_____
• Diet pills: Meridia, Xenical	_____	_____	_____
• Diet pills: phen-fen, Redux,	_____	_____	_____
• NutriSystem / Jenny Craig	_____	_____	_____
• OTC diet pills	_____	_____	_____
• Obesity Surgery	_____	_____	_____
• Registered Dietitian	_____	_____	_____
• Other	_____	_____	_____

14. Have you maintained any weight loss for up to 1 year on any of these programs? Yes No

15. What did you learn from these programs regarding your weight? _____

16. What did not work about these programs? _____

17. Have you been involved in physical activity programs to help with weight loss? Yes No

Which ones or in what way? _____

Eating Pattern Questionnaire

Please answer the following questions and check the appropriate boxes that most closely describe your eating patterns.

1. Do you follow a special diet?

- | | | |
|---------|----------|------------|
| No | Diabetic | Low sodium |
| Low fat | Kosher | Vegetarian |
| Other | | |

Give examples of what guidelines or diets, if any, you follow: _____

2. Which meals do you regularly eat?

- | | | | |
|-----------|-------|--------|--------|
| Breakfast | Lunch | Brunch | Dinner |
|-----------|-------|--------|--------|

3. When do you snack?

- | | | |
|------------|--------------------|---------|
| Morning | Afternoon | Evening |
| Late night | Throughout the day | |

What are your favorite snack foods? _____

4. Do you eat out or order food in?

- | | |
|-----|----|
| Yes | No |
|-----|----|

How often?

- | | | | |
|-------|--------|---------|-------|
| Daily | Weekly | Monthly | Other |
|-------|--------|---------|-------|

What kind of restaurant(s)/eating facilities? _____

What kinds of cuisine? _____

5. How is your food usually prepared? (check all that apply)

- | | | | |
|---------|---------|--------|-------|
| Baked | Broiled | Boiled | Fried |
| Steamed | Poached | Other | |

6. How many times each day do you have the following food items?

a. Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

b. Fruit

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

c. Vegetables

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

d. Dairy (milk, yogurt)

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

e. Meat, fish, poultry, eggs, cheese

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

f. Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

g. Sweets (candy, cake, regular soda, juice)

- | | | | | | |
|-------|-------------|-----|-----|-----|------|
| Never | Less than 1 | 1-2 | 3-5 | 6-8 | 9-11 |
|-------|-------------|-----|-----|-----|------|

7. What beverages do you drink daily and how much?

- | | |
|---------|--|
| Water | _____ times or glasses per day (8 oz) |
| Coffee | _____ times or cups per day |
| Tea | _____ times or cups per day |
| Soda | _____ times or glasses per day (12 oz) |
| Alcohol | _____ times or glasses per day (12 oz) |
| Other | _____ times or glasses per day |

(Specify) _____

8. Would you like to change your eating habits?

- | | |
|-----|----|
| Yes | No |
|-----|----|

Which habits would you like to begin to change?

