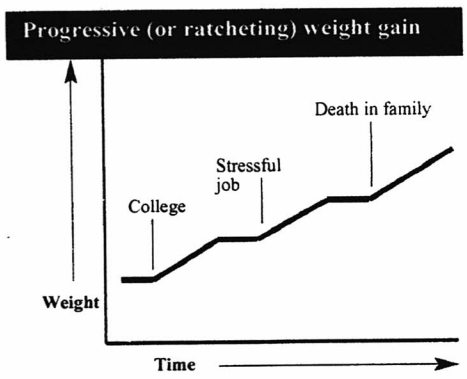
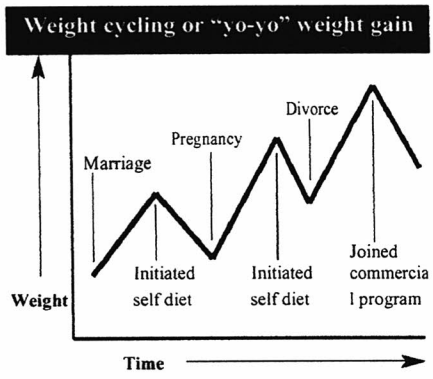
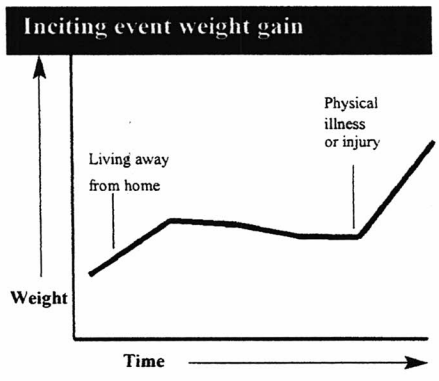
Part 1: Graphing Your Weight Gain

Patient name _____ Date _____

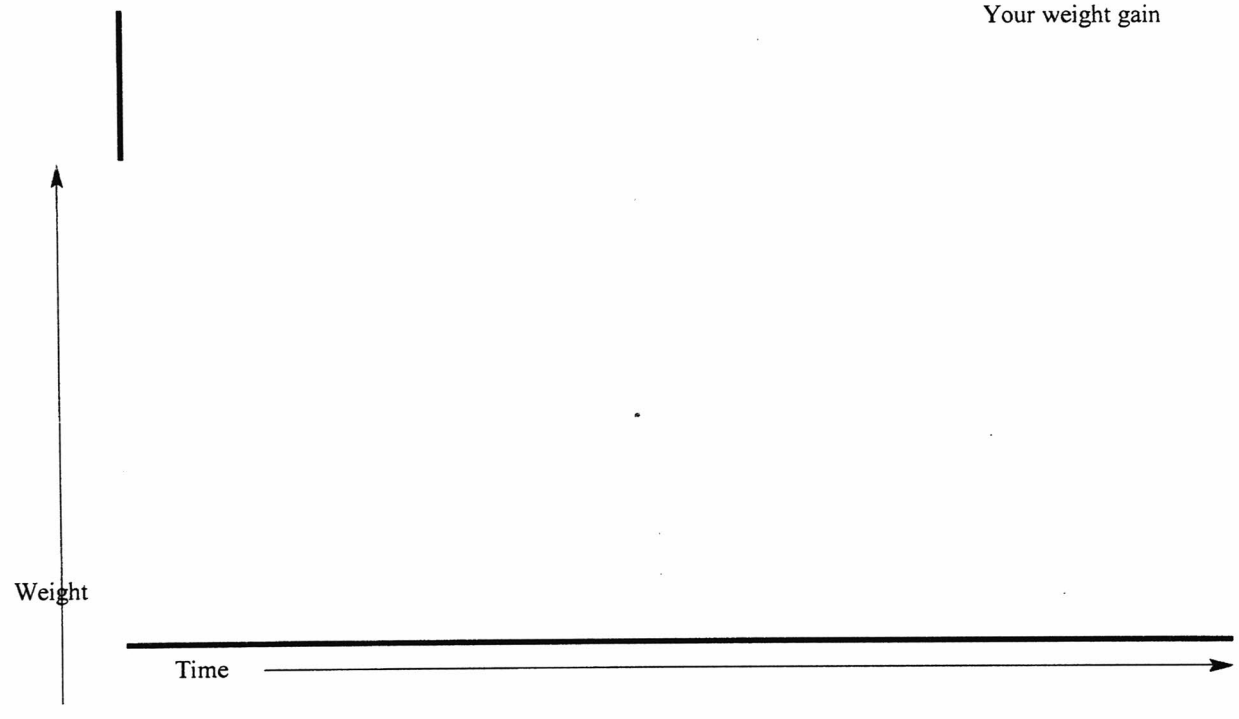
People gain weight in different ways — some gain in a progressive upward fashion, others gain in an up and down cyclical fashion, and others after a long period of controlled weight see their weight climb steadily after one inciting event. Commonly, though, most people can relate their changes in weight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

Please bring a list of your medications to your appointment.