LEAF Weight Management Clinic
Patient History Questionnaire

Instructions:

Please bring the completed form with you to your first appointment at LEAF.

For privacy, please do not mark your name on this form.

This form takes about approximately 20-30 minutes to fill.

Section I: Weight History

1) Current weight? _____ lbs

Heaviest weight? _____ lbs What age? _____

Lowest weight? _____ lbs What age? _____

(maintained for at least 1 year since age 20)

For women: this would be non-pregnant weight

2) Birthweight? _____ lbs ❑ I don't know

Where you born premature? ❑ Yes ❑ No ❑ I don't know

3) Which statement best describes your weight in childhood?

- ❑ I was overweight through most or part of my childhood.
- ❑ I was mildly overweight or chubby through most or part of my childhood.
- ❑ I was thin or "normal" weight throughout childhood.

4) Which statement best describes your weight at puberty?

- ❑ I continued to be overweight throughout puberty.
- ❑ I became overweight for the first time at puberty.
- ❑ I lost weight to normal at puberty.
- ❑ I was at normal weight at puberty.

"Puberty" for men means the year your voice changed and had a growth spurt.

5) WOMEN:
How old were you when menstruation (periods) started? _____ years old

MEN:
How old were you when your voice changed and had a major growth spurt? _____years old

6) Which years of age have you been overweight? (Check all that apply)

❑ younger than 8 years ❑ 8-10 ❑ 11-13 ❑ 14-16

❑ 17-19 ❑ 20-25 ❑ 26-30 ❑31-40

❑ 41 -50 ❑ 51-60 ❑ 61-70 ❑ older than 71

7) Can you date the onset of your weight problem to a specific year? ❑ Yes ❑ No

If yes, what age were you then? _____ years old

8) Do you connect your weight problem to a specific life event? ❑ Yes ❑ No

If yes, what was it? _____

9) Do you have a desired weight? ❑ Yes ❑ No

If yes, what weight do you hope to achieve? _____ lb

Section II: Lifestyle

1) Over the last 6 months have you been prevented from exercising because of your health?

❑ No ❑ Yes; If yes, please check all factors that prevent you from exercising:

❑ Overweight	❑ Arthritis, joint pain	❑ Limb amputation
❑ Fracture/sprain	❑ Hemi/Quadriplegia	❑ Lack of interest
❑ Heart problems	❑ Asthma	❑ Dislike

❑ Other: _____

2) **Daily Energy Expenditure**

Fill the average number of hours spent on respected activity levels considering the example activities below. Decimal values are allowed (e.g. 2.5, 0.25). The total must equal 24 hours.

___ Hrs **Resting**: Sleeping, reclining

___ Hrs **Very light**: Seated and standing activities, painting trades, driving, laboratory work, typing, sewing, ironing, cooking, playing cards, playing a musical instrument

___ Hrs **Light:** Walking on a level surface at 2.5 to 3 mph, garage work, electrical trades, carpentry, restaurant trades, house cleaning, child care, golf, sailing, table tennis

___ Hrs **Moderate:** Walking 3.5 to 4 mph, weeding and hoeing, carrying a load, cycling, skiing, tennis, dancing, weight training including rest between sets.

___ Hrs **Heavy:** Walking with load uphill, tree felling, heavy manual digging, basketball, climbing, football, soccer

3) **Current Physical Activity / Weekly Exercise Routine:**

DAY	ACTIVITY	TIME / DURATION
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

4) **Schedule:** Please provide your typical weekly, work and social schedule

	Monday	Tuesday	Wed	Thursday	Friday	Saturday	Sunday
Wake Time							
Work Hours							
Other activities (meetings, social engagements, etc)							
Bed Time							

5) Smoking history:

What statement best describes your smoking history?

- ❑ I have never smoked. (If you have never smoked go to question 6)
- ❑ I smoke (If so, how many cigarettes per day?) _____
- ❑ I quit smoking. (If so, how many years ago?) _____

How many times during your life have you stopped smoking for more than 4 weeks? _____

For how many years have you smoked? _____

On average, how many cigarettes per day have you smoked over this time? _____

6) In the last 6 months, have you used recreational drugs? ❑ Yes ❑ No
(Cannabis, marijuana, grass, hash, cocaine, etc.)

7) In the last 6 months, please describe your alcohol intake.

I am a non-drinker? ❑ Yes ❑ No

I drink alcohol most weeks? ❑ Yes ❑ No

I drink alcohol only on holidays and specific occasions? ❑ Yes ❑ No

I drink in binges? ❑ Yes ❑ No

If yes: How many days do the binges last? _____

How many times per year do they occur? _____

I have had a problem with alcohol in the past and now drink very little or nothing? ❑ Yes ❑ No

If yes: How long have you been alcohol free? _____ years _____ months

8) In the average week over the last 6 months, please estimate how much of each of the following would you use:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Beer (a 12 oz/360ml portion)							
Wine (a 5 oz/150ml portion)							
Spirits (Scotch, Gin Rum etc.) (a 1.5 oz/45ml portion)							

9) Eating Pattern :

Please fill out a typical day of eating:

Breakfast Time: _____	Lunch Time: _____	Supper Time: _____
AM snack Time: _____	Afternoon snack Time :_____	Evening snack Time: _____

Is there a particular time of day that you find challenging for eating?

❑ No ❑ Yes

If yes, when? _____

And why? _____

Counting all meals and any snacks you may have, how many times a day do you eat:_____

Thinking about your **usual or normal week**, how many days out of the 7-day week do you:

Eat breakfast: _____

Eat brunch/lunch: _____

Eat dinner: _____

In a **usual or normal week**, please fill out how many days a week do you eat out at a fast food restaurant or other type of restaurant: _____

	Breakfast	Brunch/Lunch	Dinner
Fast food restaurants	_____ days/wk	_____ days/wk	_____ days/wk
Other types of restaurants	_____ days/wk	_____ days/wk	_____ days/wk

Please fill out how much you drink of:

Water:	❑ none	❑ cups per day:_____ or cups per week:_____
Caffeinated coffee:	❑ none	❑ cups per day:_____ or cups per week:_____
Decaf coffee:	❑ none	❑ cups per day: _____or cups per week:_____
Caffeinated tea:	❑ none	❑ cups per day:_____ or cups per week:_____
Decaf tea:	❑ none	❑ cups per day:_____ or cups per week:_____
Regular pop:	❑ none	❑ cups per day:_____ or cups per week:_____
Diet pop:	❑ none	❑ cups per day:_____or cups per week:_____
Juice:	❑ none	❑ cups per day:_____ or cups per week:_____
Milk:	❑ none	❑ cups per day:_____ or cups per week:_____

10 Do you consider yourself an "emotional eater"? ❑ Yes ❑ No

11 Have you ever had a diagnosis of:

Anorexia Nervosa?	❑ Yes	❑ No
Bulemia?	❑ Yes	❑ No
Binge Eating Disorder?	❑ Yes	❑ No

12 Have you ever been referred to an Eating Disorder Clinic? ❑ Yes ❑ No

13 Have you ever made yourself vomit after overeating? ❑ Yes ❑ No

14 Do you have times when you binge?

❑ Yes ❑ No (If no, skip to question 14)

A "binge" is a large amount of food eaten in a short short time (usually less than 2 hours)and usually outside of regular meal times

If Yes, which of the following might cause you to binge (check all that apply):

❑ No particular reason ❑ Boredom ❑Sadness/depression ❑Anger
❑ Relationship issues ❑ Hunger ❑ Parenting difficulties ❑ Stress

After you binge, do you have feelings of self-criticism, depression or guilt?
❑ Yes ❑ No

Over the last 6 months, how often would you binge:
❑ Never ❑ every day ❑ Once a week ❑ More than once a week
❑ Several times a month ❑ Occasionally ❑Premenstrual week only

Part III: Prior weight management strategies:

1) Have you ever taken medications for weight loss?

❑ No (skip to question 2)

❑ Yes If Yes, please check all medications that apply:

❑ Xenical ❑ Meridia ❑ Victoza ❑ Saxenda ❑ Fen-Phen

❑ Ionamine ❑ Other:_____

2) Have you ever had surgery for weight loss?

❑ No (skip to question 3)

❑ Yes If Yes, please check what type of surgery:

❑ Lap-band ❑ Roux-en-Y gastric bypass

❑ gastric sleeve ❑ Vertical banded gastroplasty (stomach stapling)

❑ Duodenal switch ❑ Biliopancreatic diversion

❑ I had bariatric surgery but cannot recall what kind

3) Please complete this table on types of weight loss programs you have tried. Include the year, number of months in the program, pounds lost and how long the weight was kept off.

If you answered yes to Question 1 or 2, please include these answers in this table.

Program	Year	Number of Months	Weight loss in lbs	How long did you keep the weight off?
Here are some examples of programs: Weight Watchers, TOPS, medically supervised programs, Overeaters Anonymous, Registered Dietitian, or self-directed (South Beach, Atkins, GI Diet, etc)				

Part IV: Medical Conditions

1) In the last year, have you had? (Check all that apply)

❑ low back pain ❑ painful feet ❑ knee pain ❑ hip pain

❑ shortness of breath ❑ heartburn or hyperacidity

❑ stress incontinence (women)

Have you ever been told you have any of the following conditions?

2)

			If Yes, when did you find out? Month & Year
High blood pressure	❑ No	❑ Yes	_____
Cholesterol abnormalities	❑ No	❑ Yes	_____
High blood sugar or diabetes	❑ No	❑ Yes	_____
Fatty liver	❑ No	❑ Yes	_____
Thyroid problems	❑ No	❑ Yes	_____
Heart attack/angina/coronary artery disease	❑ No	❑ Yes	_____
Stroke/TIA	❑ No	❑ Yes	_____
Have you ever been hospitalized for a heart attack or angina or stroke/TIA?	❑ No	❑ Yes	_____
Deep vein thrombosis (DVT)/ pulmonary embolism	❑ No	❑ Yes	_____
Gout or high uric acid	❑ No	❑ Yes	_____
Hepatitis (Hep C, chronic active hepatitis, etc.)	❑ No	❑ Yes	_____
Inflammatory Bowel Disease (Crohns' or Ulcerative Colitis)	❑ No	❑ Yes	_____
Irritable bowel syndrome	❑ No	❑ Yes	_____
Gallstones	❑ No	❑ Yes	_____

Have you had your gallbladder removed? ❑ No ❑ Yes _____

Kidney stones ❑ No ❑ Yes _____

Sleep apnea ❑ No ❑ Yes _____

If Yes, are you presently using a CPAP machine for sleep apnea ❑ No ❑ Yes

3) The following questions are related to sleepiness:

Are you likely to fall asleep during meetings? ❑ No ❑ Yes

Are you likely to fall asleep while watching TV? ❑ No ❑ Yes

Are you likely to fall asleep while waiting for a traffic light? ❑ No ❑ Yes

Have people ever complained about your snoring? ❑ No ❑ Yes ❑ Unknown*

Has your partner ever expressed concern that you stop breathing during your sleep? ❑ No ❑ Yes ❑ Unknown*

**If there is no one available to observe your sleep.*

5) Do you have any other medical conditions or ongoing treatments at this time?

_____

_____

_____

_____

_____

6) Please list any hospital admissions you have had and the last year it happened:

Reason for admission: Year:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Part V: Medications, Vitamins, Supplements, Allergies

Prescription Medication Name	Dose	Number of times taken DAILY or as needed		Number of times taken MONTHLY
			OR	

List over-the-counter medications, supplements, or herbal preparations:

_____

_____

Allergies to medications:

_____

_____

Allergies or intolerances to food or environment:

_____

Part VI: Family History

1) Were you adopted? ❑ Yes ❑ No

   If Yes, <u>and</u> you do not know about your biological relatives, go to Part VII.

2) For first degree relatives (parents, siblings, children) is there a history of weight issues?

   ❑ Yes ❑ No

   If Yes, who struggled with weight? _____

3) Have first degree relatives (parents, siblings, children) had any of the following health conditions? (females before age 65 or males before age 55)

   ❑ Diabetes (adult onset) ❑ Angina ❑ Heart attack ❑ Stroke

Part VII: For Women Only

1) Last menstrual period _____ Year/Month ❑ Unsure

2) Date of menopause _____ Year/Month ❑ Unsure

3) Last pelvic exam _____ Year/Month ❑ Unsure ❑ None

4) Last pap smear _____ Year/Month ❑ Unsure ❑ None

5) Last breast exam _____ Year/Month ❑ Unsure ❑ None

6) Last mammogram _____ Year/Month ❑ Unsure ❑ None

7) Are you on oral contraceptives? ❑ Yes ❑ No

8) Are you on hormone replacement therapy? ❑ Yes ❑ No

9) If you are having menstrual periods:

Are they regular? ❑ Yes ❑ No

Are they regular because of medications? ❑ Yes ❑ No

If yes, please list which medications: _____

10) If your menstrual periods have stopped:

Was it due to menopause? ❑ Yes ❑ No

Was it due to hysterectomy? ❑ Yes ❑ No

Was it some other reason? ❑ Yes: _____

11) Please list the number of full term pregnancies and their effect on your weight:

Did you have gestational diabetes during pregnancy? ❑ Yes ❑ No

Are you currently pregnant? ❑ Yes ❑ No

Pregnancy	Year	Did your weight normalize after this pregnancy?		If yes, for how long did it stay normal (in months)?
#1		❑ Yes	❑ No	
#2		❑ Yes	❑ No	
#3		❑ Yes	❑ No	
#4		❑ Yes	❑ No	
#5		❑ Yes	❑ No	

Thank you!

Please bring to your medical appointment.