



Medical Weight Management Programs with a Proven Track Record

## Metabolic Nutrition Program Questionnaire

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Home Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security Number \_\_\_\_\_

Sex: Male / Female

Height \_\_\_\_\_ Weight \_\_\_\_\_

Birth date \_\_\_\_\_

Referred by \_\_\_\_\_

Your education (Please circle the most advanced stage you attained) -

Trade School / No high school diploma / High school graduate

College / No degree / College graduate / Post graduate degree

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Marital Status (Circle one):

single / married / separated / divorced / widowed / remarried / single parent

Ethnicity (Circle one):

Asian / African-American / Hispanic / White / Indian / Other\_\_\_\_\_

Religion (Circle one) :

Catholic / Protestant / Jewish / Mormon / No Preference / Other

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PAST MEDICAL HISTORY

MEDICATION, Name and Dosage

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ALLERGY TO MEDICATION

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MAJOR MEDICAL ILLNESS (Please circle)

- |                       |                          |                                  |                  |
|-----------------------|--------------------------|----------------------------------|------------------|
| Hypertension          | Diabetes mellitus        | High cholesterol or triglyceride |                  |
| Heart attack / Angina | Congestive Heart Failure | Stroke                           | Depression       |
| Esophagitis / Ulcers  | Gall bladder disease     | Irritable Bowel Syndrome         |                  |
| Sleep apnea           | Fatty liver              | Cancer                           | Kidney disease   |
| Emphysema / Asthma    | Arthritis                | Back Pain                        | Thyroid disorder |

PREVIOUS HOSPITALIZATIONS AND SURGERY

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PLEASE LIST ALL PHYSICIANS YOU CURRENTLY SEE:

Name, Address, Phone

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Do you smoke cigarettes? Yes / No

Have you quit smoking? Yes / No How long ago? \_\_\_\_\_

How many times have you tried to quit? \_\_\_\_\_

Do you have a problem with alcohol? Yes / No

Do you have a problem with drugs? Yes / No

What drug and for how long? \_\_\_\_\_

Are you presently, or have you ever been, in psychotherapy? Yes / No

If yes when and for how long? \_\_\_\_\_

Were you abused as a child? Yes / No

Are you presently abused as an adult? Yes / No

Have you experienced difficulty with sexual performance? Yes / No

Do you snore? Yes / No

Do you stop breathing at night? Yes / No

Do you experience unusual daytime fatigue? Yes / No

Do you fall asleep uncontrollably during the day? Yes / No

Do you have problems with (Please circle):

Headache / Visual problems / Hearing difficulty / Nasal disorders / Trouble swallowing

Chest pain / Shortness of breath-Day / Night Cough / Palpitations / Abdominal pain

Nausea / Vomiting Diarrhea / Constipation / Urinary problems / Menstrual irregularity

Arthritis or Pain (circle)

Neck / Back / Hips / Knees / Ankles / Feet

Numbness / Tingling / Weakness

Have you ever been normal weighted? Yes / No

Until what age? \_\_\_\_\_

Weight at birth \_\_\_\_\_

Preschool weight (Please circle)    Normal    Overweight    Underweight

Elementary school weight            Normal    Overweight    Underweight

Weight in high school \_\_\_\_\_

Weight 5 years ago \_\_\_\_\_

Weight 1 year ago \_\_\_\_\_

Maximum weight \_\_\_\_\_ Age at that time \_\_\_\_\_

Weight when married \_\_\_\_\_ Age at that time \_\_\_\_\_

Family members who are overweight:

Mother    Father    Siblings    Children

How many times have you tried to lose weight? (Please circle):

0-10    11-20    21-50    51-75    76-99

How many times have you lost 20-39 pounds? \_\_\_\_\_

How many times have you lost 40 pounds or more? \_\_\_\_\_

Have you ever attended?            When, and for how long?

Weight Watchers \_\_\_\_\_

Jenny Craig \_\_\_\_\_

OptiFast, or similar fasting program \_\_\_\_\_

Physician supervised diet program \_\_\_\_\_

Overeater's Anonymous \_\_\_\_\_

AA \_\_\_\_\_

Diet pill clinic \_\_\_\_\_

Please circle any of the following reasons for gaining weight that apply to you:

- |                     |                   |                               |                 |
|---------------------|-------------------|-------------------------------|-----------------|
| No Reason           | Marriage          | Quit smoking                  | Pregnancy       |
| Birth Control Pills | Past pregnancy    | Death in family               | Child Care      |
| Divorce             | Aging             | Surgery                       | Illness         |
| Medications         | Job problems      | Pressure of working near food |                 |
| Lack of exercise    | Boredom           | Lack of nutritional knowledge |                 |
| Cooking             | Overeating        | Bad habits                    | Holidays        |
| Nervous tension     | Compulsive eating | Psychological                 | Family problems |