Washington University in St. Louis Physicians

Weight Management Questionnaire

This questionnaire is designed to obtain information about your current situation. This information will be used for screening purposes and to help you be successful in your weight loss endeavors. This questionnaire is confidential.

PERSONAL INFORMATION

Today's Date _____ /_____/ _____

Name_____ Date of Birth _____ /_____/ _____

Occupation _____

Please indicate how satisfied you are with your occupation (Check one)

☐ 1=Very Satisfied ☐ 2=Satisfied ☐ 3=Neutral or Mixed Feelings ☐ 4=Dissatisfied

On average, how many hours do you work per week? _____

Highest year of school completed (Check one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 High School: ☐ 9 ☐ 10 ☐ 11 ☐ 12

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Masters ☐ Doctorate

What is your current marital status?

☐ Single (never married) ☐ Married– How long? _____

☐ Remarried ☐ Separated

☐ Widowed ☐ Divorced

☐ Significant Other

What is your current living situation?

☐ Live alone ☐ Live with spouse

☐ Live with significant other ☐ Live with spouse and children

☐ Live with children ☐ Live with parents/step-parents

☐ Other _____

Please list the names and ages of your children

Child	Age	Child	Age

Date_____ /_____/_____

Name _____

MEDICAL HISTORY

Medical Condition(s) Check all that apply

- ☐ High blood pressure_____
- Heart disease
  - ☐ Coronary artery disease_____
  - ☐ Heart failure _____
  - ☐ Abnormal rhythm/AFib _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Hyperlipidemia _____
- ☐ Kidney disease_____
- ☐ Sleep apnea _____
- ☐ Asthma/emphysema_____
- ☐ Cancer_____
- ☐ Heartburn/acid reflux _____
- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Thyroid disease _____
- ☐ Arthritis _____
- ☐ Alcohol/substance abuse_____

Other/Details _____

Surgical History

Procedure	Year	Procedure	Year

Drug Allergies

Drug	Reaction	Drug	Reaction

Medications (Prescription and Over-the-Counter)

Name of Medication	Dose	Approximate Start Date

Date_____ /_____/_____

Name _____

Family History Check all that apply

	Mother	Father	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4
Age (or age at death)	____	____	____	____	____	____	____	____	____	____
Overweight/obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Details/additional info_____

_____

_____

TOBACCO AND ALCOHOL USE

Do you smoke cigarettes? ☐ Yes ☐ No ☐ Previously

Years smoked_____ Cigarettes per day _____

Do you use other tobacco products? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No ☐ Previously

If yes, type: ☐ Wine ☐ Beer ☐ Spirits ☐ Mixed drinks

How many drinks per week? _____

Have you ever had a problem with your alcohol consumption? ☐ Yes ☐ No

Date_____ /_____/_____

Name _____

WEIGHT HISTORY

1. Ideally, what would you like to weigh now?_____ pounds
2. As a child, how did your weight compare to your peers? ☐ similar ☐ lower ☐ higher
3. As best as you can recall, what was your weight (or clothing size) at the end of high school/18 years of age? _____
4. What has been your highest weight after age 21 (excluding pregnancy)?

   _____ pounds at _____ years of age
5. What has been your lowest weight (not attributable to illness) after age 21, which you have maintained for at least 1 year?

   _____ pounds at _____ years of age
6. At what age were you first overweight by 15 pounds or more (excluding pregnancy)?

   _____ years of age
7. Please list any factors that you feel have contributed to your gaining weight (stressful events; work/school; for women, pregnancy/menopause; etc.)_____

   _____

   _____
8. What makes you want to lose weight now?_____

   _____

   _____
9. Please list the diets/plans/programs you have tried in the past

Diet/Plan	Year	Amount of Weight Lost	How long did you keep the weight off?

Date_____ /_____/_____

Name _____

EATING HABITS

1. Are your eating habits different on weekends? . . . . . ☐ Yes ☐ No
   If yes, how?_____
   _____
2. Do you eat regular, discrete meals, or do you feel like you eat all day?
   _____
3. Does your eating ever feel out of control? . . . . . ☐ Yes ☐ No
   If yes, when/how? _____
   _____
4. Do you ever eat large amounts of food in a short period of time (binge)?. . . . . ☐ Yes ☐ No
   If yes, how often? _____
5. After a binge, do you:
   a) take laxatives? . . . . . ☐ Yes ☐ No
   b) take diuretics? . . . . . ☐ Yes ☐ No
   c) force yourself to vomit? . . . . . ☐ Yes ☐ No
   d) "fast"? (i.e., eat very little) . . . ☐ Yes ☐ No
   e) exercise strenuously? . . . . . ☐ Yes ☐ No
6. Do you ever eat until you are so full that you are uncomfortable? . . . . . ☐ Yes ☐ No
   If yes, when/how often?_____
   _____
7. How much of your day do you spend thinking about food/weight/dieting? _____%
   _____
8. How often do you eat out?_____
   _____
9. How often do you eat fast food?_____
   _____
10. Does your work require that you eat out often? . . . . . ☐ Yes ☐ No
    If yes, how often? _____
    _____
11. Does your job require you to travel? . . . . . ☐ Yes ☐ No
    If so, how often? _____
    _____
12. Do you follow a special diet (Kosher, vegetarian, gluten-free, etc.)?. . . . . ☐ Yes ☐ No
    If yes, specify _____
    _____

Date_____ /_____/_____

Name _____

PHYSICAL ACTIVITY

1. Do you have a sedentary job? . . . . . ☐ Yes ☐ No
2. On average, how many days a week do you do some type of exercise? _____
3. How many minutes do you typically exercise at one time? _____
4. Please list any physical activity that you engage in on a regular basis. Please indicate how often and for how long you engage in the activity.

Activity	Frequency	Duration

5. Do you enjoy exercise? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly
6. What are your greatest obstacles to exercising regularly? _____

_____

_____

_____

_____

_____

Date_____ /_____/_____

Name _____

SLEEP HISTORY

1. How is your energy level in general? _____
2. On average, how many hours of sleep do you get each night? _____
3. Do you have trouble falling asleep? . . . . . ☐ Yes ☐ No
4. Do you wake frequently during the night? . . . . . ☐ Yes ☐ No
5. Do you fall asleep inappropriately during the day (such as while driving)? . . . . . ☐ Yes ☐ No
6. Do you snore? . . . . . ☐ Yes ☐ No
7. Has anyone ever told you that you choke or stop breathing at night? . . . . . ☐ Yes ☐ No
8. Do you feel rested when you get up in the morning? . . . . . ☐ Yes ☐ No
9. Do you wake up with a headache in the morning? . . . . . ☐ Yes ☐ No

GENERAL WELLBEING

1. How have you been feeling in general (during the past month)?
   ☐ In an excellent mood ☐ In a very good mood ☐ In a good mood mostly
   ☐ Up and down in mood ☐ In a low mood mostly ☐ In a very low mood
2. How stressful has your life been during the past 6 months?
   ☐ Much less stressful than usual ☐ Less stressful than usual ☐ Average
   ☐ More stressful than usual ☐ Much more stressful than usual
3. Have you been sad or depressed during the past month?
   ☐ Extremely so, to the point of being sick or almost sick ☐ Very much so
   ☐ Quite a bit ☐ Some, enough to bother me ☐ A little ☐ Not at all
4. Have you felt anxious or worried during the past month?
   ☐ Extremely so, to the point of being sick or almost sick ☐ Very much so
   ☐ Quite a bit ☐ Some, enough to bother me ☐ A little ☐ Not at all
5. Do you currently see a counselor or therapist or have you in the past? . . . . . ☐ Yes ☐ No

   _____

   _____

6. How would you describe your support system? (friends/family/coworkers)_____

   _____

   _____

   _____

   _____

Date_____ /_____/_____

Name _____

REVIEW OF SYSTEMS

Do you currently, or do you frequently have any of the symptoms below? Please provide details below the chart.

General

☐ Yes ☐ No Weight gain/loss
☐ Yes ☐ No Fever/chills
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Insomnia

Head and Neck

☐ Yes ☐ No Headache
☐ Yes ☐ No Neck pain
☐ Yes ☐ No Lumps/swelling in neck

Eyes/Ears/Throat

☐ Yes ☐ No Visual disturbance/loss
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Sore throat
☐ Yes ☐ No Dry mouth

Respiratory

☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Cough
☐ Yes ☐ No Snoring

Cardiovascular

☐ Yes ☐ No Chest discomfort/pain
☐ Yes ☐ No Rapid heart rate
☐ Yes ☐ No Swelling in legs

Gastrointestinal

☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Nausea/vomiting
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation

Genitourinary

☐ Yes ☐ No Frequent urination
☐ Yes ☐ No Irregular menses
☐ Yes ☐ No Erectile dysfunction

Musculoskeletal

☐ Yes ☐ No Joint pain/swelling
☐ Yes ☐ No Muscle pain
☐ Yes ☐ No Back pain

Neurologic

☐ Yes ☐ No Dizziness
☐ Yes ☐ No Memory loss
☐ Yes ☐ No Numbness/tingling
☐ Yes ☐ No Weakness

Dermatologic

☐ Yes ☐ No Rash
☐ Yes ☐ No Skin lesions

Hematologic

☐ Yes ☐ No Easy bleeding/bruising

Endocrine

☐ Yes ☐ No Heat/cold intolerance
☐ Yes ☐ No Excessive sweating
☐ Yes ☐ No Change in appetite
☐ Yes ☐ No Increased thirst

Psychologic

☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Trouble concentrating
☐ Yes ☐ No Decreased libido

Details/additional info_____