NEWMED
INTEGRATED HEALTHCARE

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Medical Weight Loss- Health Habits and History

Patient Name: _____DOB: _____ Date: _____

Behavior Style

Please select only one answer

☐You are always calm and easy going ☐You are usually calm and easy going ☐You are sometimes calm and easygoing
☐You are seldom calm and persistently driving for advancement ☐You are never calm and have overwhelming ambition
☐You are hard-driving and never relax

Health Habits and Personal Safety

Exercise- please select only one

☐Sedentary (no exercise) ☐Mild Exercise (climbing stairs, walking, golf)
☐Occasional Vigorous Exercise (work or recreation less than 4x/week for 30 minutes)
☐Regular Vigorous Exercise (work or recreation 4x/week or more for 30 minutes or more)

Diet

Are you dieting? ☐Yes ☐No
If yes, are you on a physician-prescribed medical diet? ☐Yes ☐No
How many meals do you eat in an average day? ____
Rank your salt intake: ☐Low ☐Medium ☐High
Rank your fat intake: ☐Low ☐Medium ☐High

Caffeine
Rank your Caffeine intake: ☐None ☐Low ☐Medium ☐High
What types of caffeine do you drink? ☐Coffee ☐Tea ☐Soda
How many cups/cans per day? ____

Alcohol
Do you drink any alcohol? ☐Yes ☐No
If yes, what kind? ☐Beer ☐Liquor ☐Wine
How many drinks per week? _____

Tobacco
Do you use tobacco? ☐Yes ☐No
☐Cigarettes-packs/day____ ☐Chew-#/day____ ☐Pipe-#/day____ ☐Cigars-#/day____
How many years? _____
If you previously used tobacco, what year did you quit? _____

Drugs
Do you currently use recreational or street drugs? ☐Yes ☐No
Have you ever taken street drugs with a needle? ☐Yes ☐No

Sex
Are you sexually active? ☐Yes ☐No
If yes, are you trying for pregnancy? ☐Yes ☐No

If you are not trying for pregnancy, what contraceptive do you use? _____

Sleep

Do you have any diagnosed sleep conditions: □Yes □No If yes, what_____

Do you have any trouble falling or staying asleep? □Yes □No

How many hours of sleep do you get per night? _____

Women Only

How old were you at the onset of menstruation? _____ Date of last menstruation? _____

How often do you get your period (days)? _____ Number of pregnancies: _____ Number of live births: ____

Heavy periods, irregularity, spotting, pain, or discharge? □Yes □No

Are you pregnant, trying for pregnancy, or breast feeding? □Yes □No

Weight History

1. What is the main reason you decided to lose weight?

2. When did you begin gaining excess weight (give reasons if known)?

3. What do you think is the main cause of your weight problem?

4. Describe your previous attempts at weight loss or previous diets have you followed. Give dates and results if possible.

5. Is your significant other overweight?

6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?

7. List any food allergies:

8. What foods do you avoid?

9. What foods do you crave?

10. Do you awaken hungry during the night?

11. What are your worst food habits?

12. What are your snack habits?

13. Rate your body from 1-10, 10 being perfect. How would you describe your body?

14. If you could change one thing about your body, what would it be?

15. What do you feel will be your obstacle(s) to successful weight loss?

16. What is your typical breakfast? What time? Where? With whom?

17. What is your typical lunch? What time? Where? With whom?

18. What is your typical dinner? What time? Where? With whom?

19. What are your weight loss goals? Overarching health goals?

20. Any additional comments you think would be helpful to the provider