DR. BOB MEDICAL WEIGHT LOSS CENTERS

□Altoona
□Johnstown
□Somerset
□Uniontown

PATIENT WEIGHT LOSS HISTORY QUESTIONNAIRE

DATE:

NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL):

1. *When did you begin to gain weight?*
   - □ After childbirth
   - □ After marriage
   - □ After an employment change
   - □ During a stressful period
   - □ Other_____

2. *How long have you been overweight?*
   - □ 1 year or less
   - □ 2-5 years
   - □ 6-10 years
   - □ >10 years

3. *What do you feel is the reason for your weight problem?*
   - □ Frequently overeating
   - □ Enjoy fattening foods
   - □ Lack of activity
   - □ Heredity
   - □ Other

4. *How many meals do you eat daily?*
   _____

5. *How many serious attempts have you made at dieting?* _____

6. *How long have you been able to stick to a diet?*
   - □ 1-2 months
   - □ 2-6 months
   - □ 7-12 months
   - □ Over 12 months

7. *What other weight reduction method have you tried?*
   - □ Weight Watchers
   - □ Other diet centers
   - □ Diet books
   - □ Physicians

8. *Why have you dropped out of diets before?*
   - □ Boredom
   - □ Hunger
   - □ Stress
   - □ Need assistance
   - □ Others

9. *What is the nature of your difficulties while dieting?* _____
   _____

10. *Are you under a physician's care?*
    □ Yes □ No

11. *Have you been advised by your physician to lose weight?*
    □ Yes □ No

12. *Do you have any physical problems that you know are associated with your weight?*
    _____
    _____

13. *Why do you want to lose weight?*
    - □ Promotes social activity
    - □ Appearance
    - □ Special occasion *(please list)*
      _____
    - □ Health reasons
    - □ To please family/friends
    - □ Other

14. *Has your husband or wife encouraged you to lose weight?* □ Yes □ No
    Explain: _____
    _____

15. *How important is it to you to lose weight?*
    - □ Extremely important
    - □ Very important
    - □ Important
    - □ Not very important

16. *Do you work outside the home?*
    - □ No
    - □ Part-time
    - □ Full-time

    Occupation _____

17. *Sex:* □ Female □ Male

18. *Age:*
    - □ Under 18
    - □ 18-24
    - □ 25-34
    - □ 35-49
    - □ 50-64
    - □ Over 64

19. *Marital Status:*
    - □ Married
    - □ Divorced
    - □ Single
    - □ Widowed
    - □ Living with a partner

20. *Number of children:*_____
    *Ages:*_____

21. *Are any of your children overweight?*_____

22. *What is your current weight?*
    _____ lbs.

23. *What was your highest weight in the last 5 years?*
    _____ lbs.

24. *What was your lowest weight in the last 5 years?*
    _____ lbs.

25. *What is your target weight?*
    _____ lbs.