Weight History

Date _____

Patient Name

Last _____ First _____ Middle Initial ____

Age _____ Sex Male _____ Female _____ Other _____

Weight History

What is your approximate weight? _____ pounds/kg (*circle one*)

What is your height? _____ inches/cm (*circle one*)

How old were you when you first became more than 20 pounds (9 kg) overweight? _____

What was your weight in high school? _____ pounds/kg (*circle one*)

Were you overweight as a child? Yes ☐ No ☐

What was the highest weight you have been in your life? _____ pounds/kg (*circle one*)

Have any of your close relatives been overweight or had obesity?

Mother ☐ Father ☐ Siblings ☐ (*check all that apply*)

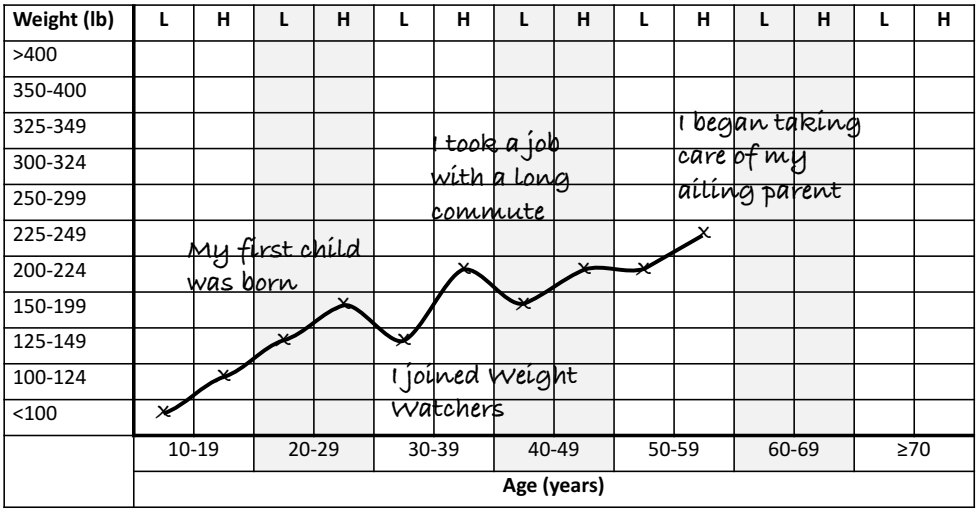
Weight History

Weight Treatment History

Chart Your Weight History

To the best of your recollection, indicate your lowest (L) and highest (H) weight during each time interval by putting an X in the corresponding box in the chart below, then connect the X's with a line. Write down anything you remember that might have contributed to your weight gain or weight loss.

Example:



Weight (lb)	L	H	L	H	L	H	L	H	L	H	L	H	L	H
>400														
350-400														
325-349														
300-324														
250-299														
225-249														
200-224														
150-199														
125-149														
100-124														
<100														
	10-19		20-29		30-39		40-49		50-59		60-69		≥70	
	Age (years)													

Weight History

Weight Management History

Have you ever been treated by a doctor for your weight? Yes ☐ No ☐

When (year)? _____

Were you successful? Yes ☐ No ☐ How much weight did you lose? _____

Have you ever consulted with a registered dietitian? Yes ☐ No ☐

Have you ever participated in a weight loss program? Yes ☐ No ☐

Please indicate which of the following weight loss programs that you have tried:

Program	Length of Time	Weight Lost	When?
Diet Center			
HMR			
Jenny Craig			
Lindora			
Medi-Fast			
Nutri-System			
Opti-fast			
Pro-Cal			
Weight Watchers			
Other			
Other			

Have you ever taken medication to lose weight? (*check all that apply*)

Medication	Was it effective?	Did you have side effects that made you stop taking it? (*If so, list side effect*)	When did you take it? (*List years*)
Phentermine (e.g., Adipex)			
Tenuate (diethylpropion)			
Belviq (lorcaserin)			
Contrave (naltrexone/ bupropion)			
Qsymia (phentermine/ topiramate)			

Weight History

Medication	**Was it effective?**	**Did you have side effects that made you stop taking it? (*If so, list side effect*)**	**When did you take it? (*List years*)**
Saxenda (liraglutide for weight loss)			
Xenical (prescription orlistat)			
Alli (over the counter orlistat)			
Topamax (topiramate)			
Glucophage (metformin)			
Victoza (liraglutide for type 2 diabetes)			
Meridia (sibutramine)			
Phen/Fen or fenfluramine			
Herbal: _____			
Other: _____			

Surgery

Have you ever had bariatric surgery? Yes ☐ No ☐

Are you currently interested in considering bariatric surgery? Yes ☐ No ☐

Have you ever consulted a surgeon regarding bariatric surgery? Yes ☐ No ☐

Weight History

Dietary Habits

Please describe your *most common* habits for each category. Enter 0 if you do not eat that meal or snack.

Meal/Snack	Time of Day	Place (home, work, car, restaurant, take-out), Typical Foods
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening snack		
Late night snack		
Grazing (eating small amounts frequently)		

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?

Yes ☐ No ☐ If yes, about how many times? _____

Do you sometimes make yourself vomit as a means to control your weight?

Yes ☐ No ☐

Have you ever been diagnosed with (*check all that apply*):

Binge eating disorder ☐ Anorexia nervosa ☐ Bulimia ☐

Weight History

Physical Activity

Do you exercise regularly? Yes ☐ No ☐
If "yes," what kind of exercise? _____

How many times per week? _____

How many minutes per session? _____

How many hours per day do you watch television? _____

Do you work outside the home? Yes ☐ No ☐
If yes, what type of work? _____

Do you do housework? Yes ☐ No ☐ How often?_____

Do you walk to work/school? Yes ☐ No ☐ Sometimes _____ How far? _____

Feelings About Eating and General Mood

Do you feel distressed about episodes of overeating? Yes ☐ No ☐

Do you often feel like you have no control over your eating or that you are unable to stop eating? Yes ☐ No ☐

Are you often embarrassed by how much you eat? Yes ☐ No ☐

Do you frequently feel disgusted with yourself for overeating or do you feel guilty for overeating? Yes ☐ No ☐

Check the answer that best describes your feelings:

I have little interest or take little pleasure in doing things.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel down, depressed, or hopeless.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have trouble falling or staying asleep.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Weight History

I sleep too much.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel tired or have little energy.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have a poor appetite because of my mood.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I overeat because of my mood.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I feel bad about myself. I feel like a failure and/or I have a lot of guilt.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I have trouble concentrating on things or making decisions.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I move or speak slowly in a way that other people notice.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I'm restless and feel like I have to keep moving.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

I think about hurting myself or that I would be better off dead.

☐ Always ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How difficult have these symptoms made it for you to do your work, take care of things at home, or get along with other people?

☐ Extremely difficult ☐ Very difficult ☐ Somewhat difficult ☐ Not at all difficult

Weight History

Social Support

Does your family support your efforts to have a healthier lifestyle? Yes ☐ No ☐

Do you see a counselor of any kind (e.g., therapist, religious leader, addiction counselor, psychologist, psychiatrist)? Yes ☐ No ☐

Do you belong to any support groups (e.g., Weight Watchers, Overeaters Anonymous, Alcoholics Anonymous, Alanon, etc.)? Yes ☐ No ☐