NUTRITION, WEIGHT LOSS & WELLNESS QUESTIONNAIRE

Patient Name:_____ Salutation: Ms. Mrs. Mr. Dr.

Date of Birth: ____/_____/_____ Sex: M/F (Circle One) Married Single Divorced Widow

MEDICAL HISTORY

GASTROINTESTINAL (GI)

1. When was your last bowel movement?_____
2. How often do you have bowel movements?_____
3. What time of day do you have bowel movement(s)?_____
4. Do you strain when moving your bowels?_____
5. Do you have hemorrhoids?_____
6. Are you on any special diets? ___Gluten-free ___Lactose-free ____Vegan/Vegetarian _____Other

WEIGHT LOSS GOALS

1. What is your present weight? _____
2. What is your ideal weight? _____
3. When do you plan to meet your weight loss goal? (month/year) _____

WEIGHT MANAGEMENT HISTORY

1. What is your age? _____
2. What was your **highest** weight in the past 3 years? _____
3. What was your **lowest** weight in the past 3 years? _____

What weight loss programs have you tried? (select below)

Program	How Long in Program?	Long term success? (Y/N)	Are you still on this program? (Y/N)
Weight Watchers			
Jenny Craig			
NutriSystem			
E-Diets			
Other:			

What diets have you tried in the past? (select below)

Diet	How Long on diet?	Long term success? (Y/N)	Are you still on this diet? (Y/N)
Atkins Diet			
South Beach Diet			
Zone Diet			
Other:			

LIFESTYLE & ACTIVITY

1. What type of work do you do? _____
2. Do you have children? _____
3. Do you smoke? _____ If yes, how often? _____
4. Do you drink alcohol? _____ If yes, how often?_____
5. Do you drink water daily? ___Filtered ___Bottled ___Tap?
6. Are there other individuals in your immediate family (parents, siblings) that are obese? _____

7. How often do you exercise (check one)?
___ Rarely ____ 1-2 days per week ____ 3-5 days per week ____ 6-7 days per week

8. How long is your exercise activity per session? ____ None ____ <30 min ____ 30-60 min ____1 hr ___ >1hr

9. What Type of Exercise do you do regularly? (select all that apply)
____ Walking _____Jogging/Running _____Weight Training _____ Bicycling _____ Other

10. How would you describe your general stress level?_____ High _____ Moderate _____ Low

11. How many hours of sleep do you get per night?
_____ <4 hours _____ 4-5 hours _____ 6-8 hours _____ >8 hours

12. How do you feel mostly throughout the day? _____ Tired & Fatigued _____ Energetic & Alert

DIETARY & NUTRITIONAL HISTORY

Select the statement that best describes you (check one)
____TYPE 1, I can eat anything I want and not gain weight.

____TYPE 2, I can lose or gain weight by adjusting my activity level and eating habits.

____TYPE 3, I find it very hard to lose weight. I gain weight very easily and have to watch everything I eat.

1. Are you a vegetarian or vegan? _____

2. Approximately how may full meals do you eat a day? _____

3. How often do you snack between meals each day? ____ none ____ 1-2 times ____ >3 times

4. Do you drink coffee regularly? _____ If yes, how many cups a day? _____

5. Do you drink soda regularly? _____ If yes, how many cans/cups a day? _____

6. Approximately how much plain water do you drink a day (in cups): _____

DIETARY & NUTRITIONAL HISTORY*(continued)*

How would you describe your typical eating habits: (check one)

____ I eat a very healthy and balanced diet, consisting mostly of fresh fruit and vegetables, lean meats and plenty of water. I rarely eat "junk food" or fast food.

____ I eat a moderately healthy diet, but on occasion eat unhealthy foods . I eat fast food more than 3 times a week. I drink sodas sometimes.

____ I eat a mostly poor and unhealthy diet. I eat junk food almost every day and fast food more than 4 times a week. I drink sodas often instead of water.

Check all that apply:

___Do you often have cravings for sugary or other types of foods throughout the day?

___Do you struggle with eating healthy and regularly throughout the day?

1. How many times each day do you eat the following foods?
   - Starches (bread, bagels, rolls, cereal, pasta, noodles, rice, potato)
     ___Never ___1-2 ___3-5 ___6-8 ___9-11
   - Fruits ___Never ___1-2 ___3-5 ___6-8 ___9-11
   - Vegetables ___Never ___1-2 ___3-5 ___6-8 ___9-11
   - Dairy (milk, yogurt) ___Never ___1-2 ___3-5 ___6-8 ___9-11
   - Meat, fish, poultry, eggs, cheese ___Never ___1-2 ___3-5 ___6-8 ___9-11
   - Fats(butter, margarine, mayo, oil, salad dressing, sour cream, cream cheese)
     ___Never ___1-2 ___3-5 ___6-8 ____9-11
   - Sweets (candy, cake, regular soda, juice) ___Never ____1-2 ___3-5 ____6-8 ____9-11

2. What time of the day are you usually the most hungry?
   ____ Morning _____ Afternoon _____ Evening ____ Late Night

3. What meal of the day is the largest? _____ Breakfast _____ Lunch _____ Dinner

4. Do you have food cravings often? If so, what type? _____ Sweets _____ Salty _____ Carbs

5. Is there anything else pertinent to your visit today?_____