The Bariatric & Metabolic
WEIGHT LOSS CENTER

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A subsidiary of Piedmont Family Practice

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HEALTH HISTORY QUESTIONNAIRE

Name (First) _____ (MI) _____ (Last) _____

Date of Birth ____/____/____

Referred by _____

WEIGHT HISTORY AND HEALTH BEHAVIORS

Weight History

1. Desired weight? _____ Weight at age 20? _____ Weight 1 year ago? _____
2. At what age did weight become a problem for you? _____
3. What has been your highest weight? _____
4. Have there been any circumstance or life events that have triggered weight gain for you?
   __ Pregnancy __ Job Change __ New Medications __Stress
   __ Boredom __ Other _____
5. Have you lost weight in the past? _____ If so, what program/method and how much weight did you lose? _____
6. Have you ever used any prescription medications for weight loss? _____If so, how much weight did you lose with the medication, and did you experience any side effects?
   _____
7. Is your partner overweight? _____
8. What do you consider some of your barriers when it comes to managing your weight?
   __Hunger __ Cravings __Time __ Fatigue __Finances __Knowledge
9. History of Bariatric Surgery? _____ If yes, what type? _____
   Surgeon? _____ Lowest weight post-surgery? _____

Nutrition

1. How do you feel about your current eating habits? __Could be better __Pretty good overall but room for improvement __ I have great habits
2. How often do you eat out/order in a week? __1-3 __4-6 __>7
3. Are you currently following a particular eating plan? __ Yes __No. If yes, which one?
   __ Low fat __ Low carb __Keto __Mediterranean __ Vegan __ Other _____

4. Food allergies/intolerances (check all that apply)
   __ Gluten __ Dairy __Tree Nuts __Eggs __ Soy __Fish/Shellfish Other _
5. Do you drink coffee, tea, or soft drinks? _____ If so, how often? _____
6. Do you drink Alcohol? _____ If so, how often? _____
7. Do you have any cravings? _____ If so, what foods do you crave? _____
   How often? _____ What time of day? _____
8. Do you wake up at night to eat? _____
9. Triggers for eating? __Hunger __ Stress __ Boredom __ Cravings __ Time of Day __ Other _____
10. Barriers to eating healthy. __ Cooking skills __ Time __ Financial Reasons __ Access to Healthy foods __ Schedule __ Home/Work circumstances __ Other_____
11. Do you overeat? _____ Stress eat? _____ Emotional eater? _____
12. Current/Past hx of an eating disorder? __ Yes __ No If yes, please elaborate:
    _____

Typical day of Meals

Breakfast: _____
Lunch: _____
Dinner: _____

Physical Activity

1. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class? __ Never __ 1-2x/wk __3-4x/wk __ >5x/wk
2. How many minutes does each bout of exercise typically last? __ 10 min or less __ 10-20 min __ 20-30 min __>30 min
3. Type of activities you participate in regularly? __ Walking __ Biking __ Yoga __ Strength Training __ Other _____
4. List any barriers to physical activity. (Time, Joint Pain, Motivation, etc.) _____
   _____

Sleep

1. How many hours of sleep do you average per night? _____
2. Do you snore? _____
3. Have you been diagnosed with sleep apnea? _____
4. Do you have trouble falling asleep or staying asleep? _____
5. Do you work night shift or shift work? __ Yes __ No

Women Only

1. Number of Pregnancies? _____ Number of live births? _____
2. Are you pregnant or breastfeeding? _____
3. Have you ever been diagnosed with PCOS? __ Yes __ No