Jennifer Whirley-Diaz, M.D.
Medical Director
MOMI
Medical Obesity Management of Indiana
www.momiweightloss.com
2000 East 116th Street, Suite 102
Carmel, IN 46032
317 564-4464
317 564-4469 FAX

Patient Questionnaire

Date: ________________

General Patient Information

First Name ______________________ Last Name ______________________
Address ______________________
City ______________ State ____ Zip Code ________ Date of Birth ____________
Phone Numbers (work) ____________ (home) ____________ (cell) ____________
eMail ______________________
Primary Care Physician: ______________________ Phone: ________ Fax: ________
Address: ______________________
Current Occupation ______________________ Hours / Shift______________________

1. What is your marital status? Single Married Divorced Separated Widowed
2. What is your living situation?

   Living alone Living with spouse/partner Living with significant other Living with children

   Living with parents/stepparents Living with other relatives Living with roommates

3. If you live with another person, do they support your efforts to lose weight? **Yes** **No**
4. Do you have a person(s) who will support you in your weight loss efforts? **Yes** **No**
5. Is there anyone that might be UN-supportive of your weight loss? **Yes** **No**

Weight History

Current Height ____________
Current Weight ____________
What is your goal weight? ________
What has been your highest adult weight? (best estimate) ________ lbs
What has been your lowest adult weight ________ lbs. Maintained for ______ yrs.
What was your weight: 1 year ago? ________ lbs 2 years ago? ________ lbs
Were you overweight as a child? Yes No

Have you tried any of the following methods to lose weight in the past? *(Circle ALL that apply)*

Dietitian / nutritionist
Low Calorie Diet
Formal group diet program: (Weight Watchers, Overeaters Anonymous)
Exercise
Very low calorie diet (liquid, Optifast, etc.)
Hypnosis
Prescription diet drugs
Over-the-counter diet drugs
Psychological counseling/behavior modification

Do you ever use laxatives to help you lose weight? Yes No
If yes how frequently? ____________

Do you ever induce vomiting? Yes No
If yes how frequently? ____________

Did you maintain your weight loss for at least 1 year after finishing the above methods? Yes No
If no, why do you think you were not successful?

____

____

Tobacco and Alcohol Use

Do you drink alcohol? Yes No If yes, how many per day________

Do you smoke cigarettes? Never Formerly Currently

If yes, how many per day?_______ for how many years?___________

Do you have ANY history of drug or alcohol abuse? No Yes

Medical History

Please indicate whether ***you*** have any of the following medical problems: (*Circle ALL that apply)*

Diabetes mellitus

High blood pressure

High cholesterol

Angina (chest pain)

History of heart disease

History of stroke

History of heartburn

History of liver disease

History of kidney disease

History of cancer

Thyroid

Anemia or Blood Disorders

Gallbladder disease/gallstones

Mental Disorder *(please specify below)*

Low back pain

Arthritis/joint pain

History of ulcers

Sleep Apnea
(breathing or severe snoring problems at night)

Other breathing problems

Other, (please specify)

____

____

- Do any of the following medical conditions run in your family? *(Please circle ALL that apply.)*

  Diabetes Heart Attack High Blood Pressure High Cholesterol/triglycerides

- ***For Women:*** Please indicate whether you have had the following: *(Circle all that apply)*

  Infertility

  Menstrual irregularity

  Hirsutism (excess of hair growth)

  Gestational diabetes mellitus
  (diabetes diagnosed during pregnancy)

  Gestational hypertension
  (high blood pressure arising during pregnancy)

- Is there any chance that you are PREGNANT? Yes No

- Please list all present medications, doses & frequency, including vitamins and herbal products.

  ________________ ________________ ________________

  ________________ ________________ ________________

  ________________ ________________ ________________

- Are you allergic to any medications or foods? Yes No If yes, please specify:

  ____

  ____

- Have you had any of the following surgical procedures?

  Removal of gallbladder

  Removal of appendix

  Surgery on the stomach, intestines, colon or other for weight loss

  Surgery on the uterus, ovaries or fallopian tubes

Eating Patterns

Please pick the number that best describes how much the behavior influences your weight gain:

1= no effect **2** = small amount **3**=Contributes a moderate amount **4**= large amount **5**=Contributes the greatest amount

____ Overeating
____ Snacking
____ Eating when anxious /stressed
____ Eating when angry/depressed
____ Eating when alone
____ Continuing to eat because I don't feel full after a meal
____ Eating while cooking or preparing food
____ Eating when tired/bored
____ Eating when happy

Please indicate any other factors that you feel have contributed to your weight gain.

____

____

- Who prepares the meals at home? ________________________________
- Who does the grocery shopping? ________________________________

Please specify the amount (in 8 oz. cups) of the following fluids that you typically consume per day

Milk ______ Water ______ Regular Soda ______ other __________
Fruit juice ______ Coffee/Tea ______ Diet Soda ______

- During a typical week, how many meals do you eat at a fast-food restaurant (including drive-thru & convenience stores)?
  Breakfast: ______ meals per week Lunch: ______ meals per week Dinner: ______ meals per week

- During a typical work week, how many meals do you eat at a traditional sit-down restaurant, coffee shop or cafeteria?
  Breakfast: ______ meals per week Lunch: ______ meals per week Dinner: ______ meals per week

- During the last 6 months, did you often eat an unusually large amount of food within a 2-hour period? **Yes** **No**

- Did you usually have any of the following experiences during these occasions?
  a. Eating much more rapidly than usual? **Yes** **No**
  b. Eating large amounts of food when you did not feel physically hungry? **Yes** **No**

- Do you eat most of your meals: (Please circle all that apply)
  Alone With others With Family In front of the TV or computer

- ***This section pertains to the past 6 months. Please circle ONE answer for each question.***

1. Do you ever get up to eat in the middle of the night?
Never Sometimes Half of the time Usually Always

2. How much of your daily food intake do you consume after supper?
0 – 25% 25 – 50% 50 – 75% 75 – 100%

Physical Activity

- Please describe any physical problems that limit your physical activity: ______________________________
____
- To what extent do you enjoy physical activity? Not at all Slightly Moderately Greatly
- Has any healthcare professional ever advised you NOT to exercise? No Yes
  If yes, please explain: ______________________________
  ____
- What type of physical activity/exercise do you enjoy? ______________________________
  How frequently? ____________________ For how long? ____________________

Psychological Factors

1. Have you ever had any problems with depression, anxiety, or other emotions that disrupted your normal functioning? **Yes** **No**

2. During the past month, have you felt depressed, sad, or blue much of the time? **Yes** **No**

3. Pick the sentence that best describes your overall feelings about yourself: *"In general, I am....."*

Very happy with who I am Happy with who I am Okay with who I am, but have some mixed feelings

Unhappy with who I am Very unhappy with who I am

4. Pick the sentence that best describes you: *"As compared with most people, I think I have..."*

Very good self-esteem Good self-esteem Average self-esteem Poor self-esteem Very poor self-esteem

5. Please circle if you are currently experiencing any stress in your life related to the following events:

Work	Activities related to your children	School
Health	Activities related to your parents	Moving
Relationship(s) with other(s)	Legal/financial trouble	Other __________

Please explain in a sentence any items to which you responded yes

____

____

8. What has prompted you to lose weight at this time? ______________________________

____

9. Rate how confident you are that you will be able to significantly change your eating and exercising habits. Pick a number from 1 to 10 in which **1=***"not at all confident"* and **10=***"extremely confident".*

My number=__________

- Please use the space below to discuss any other information that you think is pertinent to you in achieving weight loss in this program. ______________________________

____

How motivated are you to lose weight at this time?

Pick a number between 1 and 10, in which **:**

1=*"not motivated"* and **10**=*"greatest motivation you have ever had".*

My number =____________