PATIENT QUESTIONNAIRE
METABOLIC NUTRITON PROGRAM

NAME ____

HOME ADDRESS ______________________________________

CITY / STATE / ZIP ________________________________

DATE OF BIRTH _____________________________________

OCCUPATION ____

EMPLOYER ____

MARITAL STATUS: ___________________________________

ETHNICITY: AFRICAN-AMERICAN / ASIAN / HISPANIC / INDIAN / CAUCASIAN / OTHER

CURRENT MEDICATIONS (Dosage and how often) ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

ALLERGIES ____________________ ____________________

____________________ ____________________

MEDICAL ILLNESSES (please circle)

DIABETES	GERD/HEARTBURN	KIDNEY DISEASE
HYPERTENSION	GALL BLADDER DISEASE	THYROID DISORDER
HIGH CHOLESTEROL / TRIGLYCERIDE	FATTY LIVER	EMPHYSEMA
HEART DISEASE	ARTHRITIS	DEPRESSION
STROKE	BACK PAIN	ANXIETY
SLEEP APNEA	CANCER	

OTHER____

PREVIOUS HOSPITALIZATIONS / SURGERY (include dates)

____________________ ____________________

____________________ ____________________

____________________ ____________________

DO YOU SMOKE CIGARETTES? YES / NO

If yes, how many and for how long? ______________________________

Have you quit smoking? If yes, how long ago? ______________________________

How many times have you tried to quit? ______________________________

DO YOU HAVE A PROBLEM WITH ALCOHOL? YES / NO

DO YOU HAVE A PROBLEM WITH DRUGS? YES / NO

WHAT DRUG AND FOR HOW LONG? ______________________________

ARE YOU PRESENTLY, OR HAVE YOU EVER BEEN, IN PSYCHOTHERAPY? YES / NO

If yes, when and for how long? ______________________________

WERE YOU ABUSED AS A CHILD? YES / NO

ARE YOU PRESENTLY ABUSED AS AN ADULT? YES / NO

DO YOU SNORE? YES / NO

DO YOU STOP BREATHING AT NIGHT? YES / NO

DO YOU EXPERIENCE UNUSUAL DAYTIME FATIGUE? YES / NO

DO YOU FALL ASLEEP UNCONTROLLABLY DURING THE DAY? YES / NO

DO YOU HAVE PROBLEMS WITH (please circle symptoms that appy to you):

HEADACHE	VISUAL PROBLEMS	HEARING DIFFICULTIES
NASAL PROBLEMS	TROUBLE SWALLOWING	COUGH
CHEST PAINS	PALPITATIONS	SHORTNESS OF BREATH
ABDOMINAL PAIN	NAUSEA	VOMITING
DIARRHEA	CONSTIPATION	RECTAL BLEEDING

URINARY PROBLEMS

MENSTRUAL IRREGULARITY   PROBLEMS WITH SEXUAL ACTIVITY

NUMBNESS or WEAKNESS

ARTHRITS OR JOINT PAIN

HIPS / KNEES / ANKLE / FEET / NECK / BACK

FAMILY MEMBERS WHO ARE OVERWEIGHT:

MOTHER	BROTHER(S)	SON(S)
FATHER	SISTER(S)	DAUGHTER(S)

HOW OFTEN, AND FOR HOW LONG, DO YOU EXERCISE? ______________________

HAVE YOU EVER BEEN NORMAL WEIGHTED? YES / NO UNTIL WHAT AGE? ____________

PRE-SCHOOL WEIGHT (please circle) Normal / Underweight / Overweight

ELEMENTARY SCHOOL WEIGHT (Please circle) Normal / Underweight / Overweight

WEIGHT IN HIGH SCHOOL ____________

WEIGHT 5 YEARS AGO ____________

WEIGHT 1 YEAR AGO ____________

MAXIMUM WEIGHT ____________ AGE AT THAT TIME ____________

WEIGHT WHEN MARRIED (if applicable) ____________ AGE AT THAT TIME ____________

HOW MANY TIMES HAVE YOU TRIED TO LOSE WEIGHT?

0-10 11 to 20 21 to 50 51 to 75 79 to 99 More than 100

HOW MANY TIMES HAVE YOU LOST 20-39 POUNDS? ____________

HOW MANY TIMES HAVE YOU LOST 40 POUNDS OR MORE? ____________

HAVE YOU EVER ATTENDED? (When and for how long?)

WEIGHT WATCHERS

JENNY CRAIG

NUTRI-SYSTEMS

OPTI-FAST or SIMILAR FASTING PROGRAM

OVER-EATERS ANONYMOUS

ALCOHOLICS ANONYMOUS

PLEASE CIRCLE ANY OF THE FOLLOWING REASONS FOR GAINING WEIGHT THAT APPLY TO YOU:

No Reason	Illness	Cooking
Marriage	Aging	Overeating
Quit smoking	Surgery	Bad habits
Pregnancy	Medications	Holidays
Birth Control Pills	Job problems	Nervous tension
Past pregnancy	Pressure of working near food	Compulsive eating
Death in family	Lack of exercise	Psychological
Child Care	Boredom	Family problems
Divorce	Lack of nutritional knowledge	