PATIENT QUESTIONNAIRE
METABOLIC NUTRITION PROGRAM

NAME _____

HOME ADDRESS _____

CITY / STATE / ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

DATE OF BIRTH _____

REFERRED BY _____

HOW DID YOU HEAR ABOUT US? _____

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? _____

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

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

(Note: 2 out of 4 women have been sexually abused, harassed, and/or molested by the age of 25)

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

CHEST PAINS

PALPITATIONS

SHORTNESS OF BREATH

COUGH

ABDOMINAL PAIN

NAUSEA

VOMITING

DIARRHEA

CONSTIPATION

RECTAL BLEEDING

URINARY PROBLEMS

MENSTRUAL IRREGULARITY

PROBLEMS WITH SEXUAL ACTIVITY

NUMBNESS or WEAKNESS of ARM or LEG

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)

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? _____ 40 POUNDS OR MORE? _____

DO YOU OFTEN FEEL YOU CAN'T CONTROL WHAT OR HOW MUCH YOU EAT? YES / NO

DO YOU OFTEN EAT WITHIN ANY 2 HOUR PERIOD, WHAT MOST PEOPLE WOULD REGARD AS AN UNUSUALLY LARGE AMOUNT OF FOOD? YES / NO

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

WEIGHT WATCHERS	OPTI-FAST or SIMILAR FASTING PROGRAM
JENNY CRAIG	OVER-EATERS ANONYMOUS
NUTRI-SYSTEMS	ALCOHOLICS ANONYMOUS
OTHER, PLEASE LIST:	

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	