PATIENT QUESTIONNAIRE
METABOLIC NUTRITION PROGRAM

NAME _____ **DATE** _____

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? _____

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

WEIGHT WATCHERS
JENNY CRAIG
NUTRI-SYSTEMS
OTHER, PLEASE LIST:

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	

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

DO YOU GET UP AT NIGHT TO EAT? Y / N ARE YOU TROUBLED BY IT? Y / N

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)

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 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 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 DRINK ALCOHOL? YES / NO

If yes, how many times in the past year had you had 5 (men) or 4 (women) drinks or more in a day? ___

DO YOU USE RECREATIONAL DRUGS? YES / NO

WHAT DRUG AND FOR HOW LONG? _____

HOW OFTEN DO YOU EXERCISE? _____

TYPE OF EXERCISE: _____

DURATION: _____

WHAT IS YOUR OCCUPATION? _____

FAMILY MEMBERS WHO ARE OVERWEIGHT:

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

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

IS THERE ANYTHING ELSE REGARDING YOUR WEIGHT YOU WOULD LIKE TO DISCUSS? Y / N