NAME: _____ **DATE**:_____

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BARIATRICS

Eating Habits (circle all that apply):

Skip Meals Snack Eat Large Portions Binge Eat Eat Out Alot

Active Co-Morbidities (circle all that apply)

High Blood Pressure	Diabetes	High Lipids	Heartburn
Heart Disease	Leg Swelling	Heart Attack	Heart Failure
Sleep Apnea	Asthma	Sleep Problems	Frequent Urination
Leakage of Urine	Pain in the Joints	Low Back Pain	Blood Clots
Menstrual Change	Loss of Sexual Desire	Depression	Skin Irritation

Diet/Weight History:

Weight History

Have you ever tried to "go on a diet"? □ Yes □ No

How many attempts have been made to lose weight? □ 1-3 □ 3-10 □ 10-25 □ >25

Of these how many were successful? Please describe the outcome briefly.

_____

_____

_____

Dietary Weight Loss Attempts:

Program	Year	Pounds Lost	Pounds Regained	Cost ($)
Fen-Phen (Redux)				
Xenical				
Meridia				
Medifast				
Nutrisystem				
Weight Watchers				
Jenny Craig				

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Richards Simmons				
Atkins				
Sugar Busters				
Overeaters Anonymous				
Hypnosis				
Acupuncture				
Behavior Modification				
Surgery				
Nutrionist				
Other				

Exercise Weight Loss Attempts

Program	Year	Months on Program	Pounds Regained	Cost ($)
Health Club				
Walking				
Jogging				
Bicycling				
Swimming				
Aerobics				
Home Equipment				
Trainer				
Other				

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At what age (in years) did you first have a weight problem? (circle one)

5-10 10-15 15-20 20-30

30-40 40-50 50-60 >60

Highest adult weight _____ lbs

Weight five years ago? _____lbs

Weight two years ago? _____lbs

Weight one year ago? _____lbs

How long have you been 100lbs about your ideal weight? _____ years

Exercise Habits

Sedentary Minimally Active Moderately Active Very Active

Exercise Frequently? _____ per week

How many hours of TV do you watch? _____ per day

How many hours do you spend in front of the computer? _____ per day