WEIGHT LOSS QUESTIONNAIRE

Name __________________________________________ Date _______________________

Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

1. Is there a reason you are seeking treatment at this time? ______________________________________________________

2. What are your goals about weight control and management? ____________________________________________________

3. Your level of interest in losing weight is:

   Not interested 1 2 3 4 5                                         Very interested

4. Are you ready for lifestyle changes to be a part of your weight control program?

   Not ready 1 2 3 4 5                                         Very ready

5. How much support can your family provide?

   No support 1 2 3 4 5                                         Much support

6. How much support can your friends provide?

   No support 1 2 3 4 5                                         Much support

7. What is the hardest part about managing your weight? ______________________________________________________________________________________________

8. What do you believe will be of most help to assist you in losing weight? ______________________________________________________________________________________________

9. How confident are you that you can lose weight at this time?

   Not confident 1 2 3 4 5                                         Very confident

Weight History

10. As best as you recall, what was your body weight at each of the following time points (if they apply)?

    Grade school  ______ High school  ______ College  ______ Age 20-29  ______ 30-39  ______ 40-49  ______ 50-59  ______

11. What has been your lowest body weight as an adult? ______ Your heaviest as an adult? ______

12. At what age did you start trying to lose weight? ______

13. Please check all previous programs you have tried in order to lose weight. Include dates and length of participation.

   Program                      Date                   Weight (lost or gained)    Length of participation
   TOPS
   Weight Watchers
   Overeaters Anonymous
   Liquid diets (Optifast, etc)
   Diet pills: Meridia, Xenical
   Diet pills: phen-fen, Redux
   NutriSystem / Jenny Craig
   OTC diet pills
   Obesity surgery
   Registered dietitian
   Other

14. Have you maintained any weight loss for up to 1 year on any of these programs? ______ Yes ______ No

15. What did you learn from these programs regarding your weight? ______________________________________________________________________________________________

16. What did not work about these programs? ______________________________________________________________________________________________

17. Have you been involved in physical activity programs to help with weight loss? ______ Yes ______ No

   Which ones or in what way? ______________________________________________________________________________________________

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