**UNC Hospitals Medical Weight Program New Patient Questionnaire**

**IMPORTANT: Please complete this questionnaire and bring it with you on your first visit to the UNC Medical Weight Program.** **In addition, please bring a current list of your medications and medical diagnoses when coming for your first visit**

Please provide the name of the doctor who referred you to the program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your main reason for seeking obesity treatment? Circle ONE that applies:**

I want this for myself (“self-motivation”).

A family member insisted that I lose weight.

My physician has recommended weight loss.

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your main motivation for obesity treatment? Circle ONE that applies:**

I would like to improve my appearance.

I would like to be more active and have a better quality of life.

I would like to improve my health conditions.

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What treatments are you interested in pursuing? Circle ALL that apply.**

Lifestyle changes

Weight loss Medications

Endoscopic weight loss treatments

Weight loss Surgery

What is the weight would you like to reach? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had weight loss surgery previously? Yes / No**

**If yes, please answer the following questions, if not please move to the “ Weight History” section:**

Type of surgery:

Surgeon name:

Hospital name:

Date of procedure:

Weight prior to operation:

Lowest weight achieved after operation:

Are you taking vitamins and supplements as recommended : Yes / No

**Weight History:**

Highest adult weight\_\_\_\_\_\_\_\_\_\_lbs.

**Do you have any of the following which may suggest a genetic cause ? Circle ALL that apply**

A strong family history of obesity.

Obesity started early and has been progressive during my life.

I was excessively hungry as a child.

**Females only answer.**

I retained about \_\_\_\_\_\_\_\_\_\_lbs weight with each pregnancy.

I gained \_\_\_\_\_\_\_\_\_\_ lbs with menopause.

**Are there any other reasons for weight gain? Answer any that apply.**

I gained \_\_\_\_\_\_\_\_\_\_lbs when working night shift.

I gained \_\_\_\_\_\_\_\_\_\_lbs when I quit smoking.

I gained \_\_\_\_\_\_\_\_\_\_lbs with past medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( name).

**Dieting History:**

What diets have worked for you in the past? Please list all that apply:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the most weight that you have lost\_\_\_\_\_\_\_\_\_\_lbs.

How long did you maintain your weight loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have excessive hunger within 1-2 hours of having a regular meal? Yes / No

Are you currently working with a Registered Dietitian? Yes / No.

**Eating Behaviors:**

At times I eat when I am not hungry: Yes / No

If yes then describe when this happens and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I eat for comfort when I am stressed or emotional: Yes/ No

If yes , how frequently does this happen ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There are times when I eat and it feels like I can’t stop: Yes/ No

If yes how frequently does this happen and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have tried in the past to manage my weight by vomiting, using laxatives, diuretics: Yes /No

If yes then was the last time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sometimes find food on your bed which you do not remember eating. Yes/ No

If yes then how often does this happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I eat late at night or I wake up at night and eat. Yes/ No

If yes then how often does this happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Activity:**

**How would you describe your activity at work ? Circle ONE that applies.**

Constantly moving / Somewhat active / Mostly sedentary

Do you exercise regularly? Yes/ No

What exercise do you usually do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many minutes do you exercise each time ? \_\_\_\_\_\_\_\_\_\_\_\_\_minutes.

How many times do you exercise in a week ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am unable to exercise because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:**

I sleep at \_\_\_\_\_\_\_\_\_\_\_\_\_am/pm and wake up at\_\_\_\_\_\_\_\_\_\_\_am/pm.

I wake up \_\_\_\_\_ times a night because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My last full glass of liquid intake in the day is at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stress:**

What was your stress level during the past year on a scale of 1 to 10, With 10 being the highest stress

level.\_\_\_\_\_\_\_.

How does stress affect you on a day to day basis ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the main cause of your stress?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever used any of the following medications?**

Phentermine (Adipex-P) Yes / No / I don’t know

Metformin (Glucophage) Yes / No / I don’t know

Topiramate (Topamax) Yes / No / I don’t know

Bupropion (Wellbutrin) Yes / No / I don’t know

Lorcaserin (Belviq) Yes / No / I don’t know

Orlistat ( Alli/ Xenical) Yes / No / I don’t know

Qsymia Yes / No / I don’t know

Contrave Yes / No / I don’t know

Saxenda/ Victoza Yes / No / I don’t know

Invokana/ Farxiga/ Jardiance Yes / No / I don’t know