Welcome!

Patient ID sticker will go here

Johns Hopkins Healthful Eating, Activity & Weight Program

New Patient Questionnaire

Please answer the following questions and bring this form to your first visit. This form will become part of your confidential medical record. Leave blank any items that don't seem appropriate or you are unsure how to answer. Please fill out all pages.

Patient's Name: ______________________ Visit Date: ____ / ____ / 20____

Date of Birth: ____ / ____ / ________ Johns Hopkins History #: ______________________

Who referred you to the Healthful Eating, Activity & Weight Program?

☐ Myself ☐ Family/Friend ☐ Physician ☐ Other Healthcare Provider

Referring Provider's Name: ______________________

Address: ______________________

Telephone #: ______________________ Fax #: ______________________

What is the main reason for your visit? (Check all that apply)

☐ Weight management
☐ High blood pressure
☐ Prediabetes/Diabetes (high blood sugar)
☐ High cholesterol
☐ Fatty liver (NAFLD/NASH)
☐ Polycystic ovarian syndrome (PCOS)
☐ Menopause
☐ Infertility
☐ Lipedema
☐ Bariatric surgery
☐ Bariatric endoscopy
☐ Other bariatric procedure

☐ Other: ______________________

____

Do you have any of the following problems? (Check all that apply)

General:	☐ Fever	☐ Chills	☐ Weight gain	☐ Fatigue	☐ Abnormal sweating
Skin:	☐ Rash	☐ Itching			
ENT:	☐ Hearing loss ☐ Congestion	☐ Ringing in ear ☐ Sinus pain	☐ Ear pain ☐ Sore throat	☐ Ear discharge ☐ Goiter	☐ Nosebleeds
Eyes:	☐ Blurred vision ☐ Eye redness	☐ Double vision ☐ Yellow eyes	☐ Light sensitivity	☐ Eye pain	☐ Eye discharge
Chest:	☐ Chest pain	☐ Palpitations	☐ Claudication	☐ Leg swelling	☐ Unable to lie flat
Lungs:	☐ Cough	☐ Sputum	☐ Bloody sputum	☐ Wheezing	☐ Difficulty breathing
GI:	☐ Heartburn ☐ Constipation	☐ Nausea ☐ Blood in stool	☐ Vomiting ☐ Black stool	☐ Diarrhea ☐ Milk intolerance	☐ Belly pain ☐ Bloating
Urinary:	☐ Painful urination	☐ Blood in urine	☐ Urgency	☐ Kidney stone	☐ Frequent urination
Muscle:	☐ Muscle pain	☐ Neck pain	☐ Back pain	☐ Joint pain	☐ Falls
Neuro:	☐ Dizziness ☐ Speech change	☐ Headaches ☐ Weakness	☐ Tingling ☐ Seizures	☐ Tremor ☐ Passing out	☐ Numbness ☐ Memory loss
Mood:	☐ Depression	☐ Suicidal ideas	☐ Hallucinations	☐ Insomnia	☐ Nervous/Anxious
Other:	☐ Easy bruising	☐ Allergies	☐ Increased thirst	☐ Cold sensitivity	☐ Irregular periods

GIM HEAWP (REV 1/2023)

Name: ______________________________

Date of Birth: ______/________/______

YOUR WEIGHT & LIFESTYLE HISTORY

WEIGHT HISTORY

1. What is your lowest weight as an adult? ___________ (age______) **Highest weight?** ___________ (age_____)

2. Do you have a scale at home? ☐ Yes ☐ No

3. Have you tried any of the following strategies to lose weight in the past? (Check all that apply)

Commercial Programs, Diets, and Smartphone Apps

☐ Curves	☐ Jenny Craig	☐ LA Weight Loss	☐ Nutrisystem	☐ Weight Watchers
☐ HMR	☐ Ideal Protein	☐ Medifast	☐ Optavia	☐ OPTIFAST
☐ SlimFast	☐ Atkins	☐ DASH	☐ Intermittent fasting	☐ Ketogenic
☐ Low carb	☐ Mediterranean	☐ Ornish	☐ Paleo	☐ South Beach
☐ Vegan	☐ Vegetarian	☐ Volumetrics	☐ Zone	☐ Overeaters Anonymous
☐ TOPS	☐ Lose It	☐ My Fitness Pal	☐ Noom	

Other:____

Physical Activity

☐ Cardio	☐ Cross-training	☐ Weight training	☐ Yoga

Other:____

Medications and Supplements

☐ Phentermine	☐ Diethylpropion	☐ Phendimetrazine	☐ Benzphetamine	☐ Qsymia
☐ Contrave	☐ Saxenda	☐ Victoza	☐ Wegovy	☐ Ozempic
☐ Metformin	☐ Mounjaro	☐ Vyvanse	☐ Imcivree	☐ Plenity
☐ Xenical	☐ Alli	☐ Belviq	☐ Fen-Phen	☐ Meridia
☐ B12	☐ hCG			

Other:____

Procedures & Other Specialists

☐ Endoscopic sleeve	☐ LapBand	☐ Gastric sleeve	☐ Gastric bypass	☐ Biliopancreatic diversion
☐ Obera	☐ Reshape	☐ Obalon	☐ VBloc	☐ Aspire Assist
☐ Psychologist	☐ Dietitian	☐ Trainer	☐ Weight loss clinic	

Other:____

3-DAY LIFESTYLE DIARY

Keep track of all the foods that you eat and all the beverages that you drink for three days. Record what you are eating and how much you are eating. Record any physical activity that you do. Please eat, drink, and be active as you normally would.

	Day 1	Day 2	Day 3
Wake up	**TIME:**	**TIME:**	**TIME:**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Sleep	**TIME:**	**TIME:**	**TIME:**
Activity			

Name: ______________________________

Date of Birth: ______/________/______

4. **Who do you live with?** ____

Who does the grocery shopping? _____________________ **Cooking?** ______________________

5. **What people in your life help support you in making lifestyle changes or losing weight?** ________________________

____

EATING HABITS

6. To what degree do you believe each of the following eating habits causes you to gain weight?

	Not at All 1	2	Some 3	4	A Lot 5
Overeating at breakfast	☐	☐	☐	☐	☐
Overeating at lunch	☐	☐	☐	☐	☐
Overeating at dinner	☐	☐	☐	☐	☐
Eating too much food	☐	☐	☐	☐	☐
Snacking after dinner	☐	☐	☐	☐	☐
Snacking between meals	☐	☐	☐	☐	☐
Eating because I can't stop once I've begun	☐	☐	☐	☐	☐
Eating because I crave certain foods	☐	☐	☐	☐	☐
Eating because I feel physically hungry	☐	☐	☐	☐	☐
Continuing to eat because I don't feel full after a meal	☐	☐	☐	☐	☐
Eating with family and friends	☐	☐	☐	☐	☐
Eating when socializing or celebrating	☐	☐	☐	☐	☐
Eating at business functions	☐	☐	☐	☐	☐
Eating while cooking or preparing food	☐	☐	☐	☐	☐
Eating in response to sight or smell of food	☐	☐	☐	☐	☐
Eating when happy	☐	☐	☐	☐	☐
Eating when stressed	☐	☐	☐	☐	☐
Eating when depressed/upset	☐	☐	☐	☐	☐
Eating when angry	☐	☐	☐	☐	☐
Eating when anxious	☐	☐	☐	☐	☐
Eating when bored	☐	☐	☐	☐	☐
Eating when tired	☐	☐	☐	☐	☐

7. In the past 6 months, did you often eat an unusually large amount of food within a 2-hour period? ☐ Yes ☐ No

If YES, during the times when you ate an unusually large amount large amount of food, did you often feel that you could not stop eating or control what or how much you were eating? ☐ Yes ☐ No

PHYSICAL ACTIVITY

8. To what extent do you enjoy physical activity? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly

9. List the type and frequency of physical activities that you currently do: ☐ I do no activity

____

SLEEP, STRESS & MOOD

10. How many hours of sleep do you typically get? ______________ **11. Do you work night shift?** ☐ Yes ☐ No

12. Do you have difficulty falling asleep? ☐ Yes ☐ No **Difficulty staying asleep?** ☐ Yes ☐ No

If YES to either, do you ever eat when you are awake at night? ☐ Yes ☐ No

13. Do you experience any of the following (check all that apply)**:** ☐ snoring ☐ wake choking/gasping ☐ tossing/turning ☐ wake with dry mouth ☐ morning headaches ☐ witnessed breathing pauses while asleep

14. Do you have any greater than usual stress in your life? ____

15. During the past month, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

16. During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

17. List any other factors that contribute to your lifestyle or weight gain: ________________________________

____

Name: ______________________________

Date of Birth: ______/________/______

YOUR HEALTH HISTORY

17. Indicate if you have had any of the following:

☐ Heart attack	☐ Heart failure	☐ Heart murmur	☐ Stroke	☐ Claudication
☐ Diabetes	☐ Prediabetes	☐ High cholesterol	☐ Gout	☐ High blood pressure
☐ Sleep apnea	☐ Asthma	☐ Other lung disease	☐ Kidney disease	☐ Cancer: __________
☐ GERD	☐ Gallstones	☐ Fatty liver	☐ Other liver disease	☐ Thyroid disease
☐ Arthritis	☐ Back pain	☐ Depression	☐ Anxiety	☐ Other mental disease
☐ PCOS	☐ Infertility	☐ Menopause	☐ Incontinence	☐ Anemia

18. What other illnesses have you had? (Name and approximate date)

____

____

WOMEN ONLY: When was your last menstrual period? ______________________ ☐ Regular ☐ Irregular

19. Have you had any surgery?

Type of Surgery	Date	Facility

20. What medications do you take? (List all medications, vitamins, & supplements – both prescription and non-prescription)

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

☐ **I take no medications**

21. What allergies do you have? (List any allergies or bad reactions to medications that you have had)

Medication Name	Reaction	Medication Name	Reaction

What food allergies do you have? ____

☐ **I have no known allergies**

Name: ______________________________

Date of Birth: ______/________/______

YOUR PERSONAL AND FAMILY HISTORY

PERSONAL HISTORY

22. How many years of school have you completed? ___________________________________

23. What is your current employment status: ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Employed ☐ Student ☐ Disabled: ___________________

Current occupation: ___________________________________ Previous occupation: __________________________________

24. Have you used any of the following substances?

Substance	Current Use	Prior Use	Type	Amount/Frequency	Duration of Use	Quit Date?
Tobacco/ Nicotine	☐	☐	☐ Cigarettes ☐ Cigar ☐ Vaping			
Alcohol	☐	☐	☐ Beer ☐ Wine ☐ Liquor			
Recreational/ Street Drugs	☐	☐	☐ Marijuana ☐ Other:			

25. What is your marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

26. Have you ever been physically, sexually or emotionally abused? ☐ Yes ☐ No

FAMILY HISTORY

☐ **I am adopted**

	Sex (M/F)	**Living?** (Yes/No)	**Age**	**Obesity?** (Yes/No)	**Health Problems**
Mother					
Father					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Child					
Child					
Child					
Child					
Child					
Child					