

Welcome!

Patient ID sticker will go here

Johns Hopkins Healthful Eating, Activity & Weight Program 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 that you are unsure how to answer. Please fill out all pages.

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

Date of Birth: ____ / ____ / 20____ 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 Other: _____

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

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

Name: _____

Date of Birth: _____ / _____ / 20_____

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

- | | | | | |
|-----------------------------------|--|---|---|--|
| <input type="checkbox"/> Curves | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> LA Weight Loss | <input type="checkbox"/> Nutrisystem | <input type="checkbox"/> Weight Watchers |
| <input type="checkbox"/> HMR | <input type="checkbox"/> Ideal Protein | <input type="checkbox"/> Medifast | <input type="checkbox"/> Optavia | <input type="checkbox"/> OPTIFAST |
| <input type="checkbox"/> SlimFast | <input type="checkbox"/> Atkins | <input type="checkbox"/> DASH | <input type="checkbox"/> Intermittent fasting | <input type="checkbox"/> Ketogenic |
| <input type="checkbox"/> Low carb | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Ornish | <input type="checkbox"/> Paleo | <input type="checkbox"/> South Beach |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Volumetrics | <input type="checkbox"/> Zone | <input type="checkbox"/> OA |
| <input type="checkbox"/> TOPS | <input type="checkbox"/> Lose It | <input type="checkbox"/> My Fitness Pal | <input type="checkbox"/> Noom | <input type="checkbox"/> Dietician |

Other: _____

Physical Activity

- | | | | | |
|---------------------------------|---|--|-------------------------------|----------------------------------|
| <input type="checkbox"/> Cardio | <input type="checkbox"/> Cross-training | <input type="checkbox"/> Weight training | <input type="checkbox"/> Yoga | <input type="checkbox"/> Trainer |
|---------------------------------|---|--|-------------------------------|----------------------------------|

Other: _____

Medications and Supplements

- | | | | | |
|--------------------------------------|---|--|--|----------------------------------|
| <input type="checkbox"/> Phentermine | <input type="checkbox"/> Diethylpropion | <input type="checkbox"/> Phendimetrazine | <input type="checkbox"/> Benzphetamine | <input type="checkbox"/> Plenity |
| <input type="checkbox"/> Qsymia | <input type="checkbox"/> Contrave | <input type="checkbox"/> Saxenda | <input type="checkbox"/> Xenical | <input type="checkbox"/> Alli |
| <input type="checkbox"/> Belviq | <input type="checkbox"/> Fen-Phen | <input type="checkbox"/> Meridia | <input type="checkbox"/> B12 | <input type="checkbox"/> hCG |

Other: _____

Procedures & Other Specialists

- | | | | | |
|----------------------------------|---|---|---------------------------------------|---|
| <input type="checkbox"/> LapBand | <input type="checkbox"/> Gastric sleeve | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Obara | <input type="checkbox"/> Reshape |
| <input type="checkbox"/> Obalon | <input type="checkbox"/> VBloc | <input type="checkbox"/> Aspire Assist | <input type="checkbox"/> Psychologist | <input type="checkbox"/> 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: _____ / _____ / 20_____

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

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 each night? _____

11. 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

12. Do you have any greater than usual stress in your life? _____

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

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

15. List any other factors that contribute to your lifestyle or weight gain: _____

Name: _____

Date of Birth: _____ / _____ / 20_____

YOUR HEALTH HISTORY

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

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Claudication |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prediabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other lung disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> Other liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other mental disease |
| <input type="checkbox"/> PCOS | <input type="checkbox"/> Infertility | <input type="checkbox"/> Menopause | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Anemia |

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

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

18. Have you had any surgery?

Type of Surgery

Date

Facility

19. 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

20. 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: _____ / _____ / 20_____

YOUR PERSONAL AND FAMILY HISTORY

PERSONAL HISTORY

21. How many years of school have you completed? _____

22. What is your current employment status: Retired Unemployed Homemaker
 Employed Student Disabled: _____

Current occupation: _____ Previous occupation: _____

23. Do you ever work the night shift with your current job(s)? Yes No

24. Have you used any of the following substances?

| Substance | Current Use | Prior Use | Type | Amount/Frequency | Duration of Use | Quit Date? |
|-------------------------------|--------------------------|--------------------------|--|------------------|-----------------|------------|
| Tobacco/ Nicotine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Vaping | | | |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor | | | |
| Recreational/ Street Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Marijuana <input type="checkbox"/> 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 | _____ | _____ | _____ | _____ | _____ |