UI Weight Management

The purpose of this questionnaire is to **help you focus on your specific health issues related to being over-weight**, **help our clinic team to best address your concerns** and **help you achieve the goals you are setting for yourself**. This information is kept confidential according to Hospital policies, and will be reviewed only by the members of the UI Weight Management Team.

Name: ____

What MOST influenced your decision to contact our clinic?
___My doctor requested that I come ___My health is poor ___Find an effective way to lose weight and keep it off.

What do you hope to achieve in coming to our clinic?
___ Improve my quality of life. ___ Improve my health ___Find an effective way to lose weight and keep it off.

How ready do you feel to make needed lifestyle changes? (Circle the most appropriate value).
Not ready 1 2 3 4 5 Very ready

How did you hear about our program?
___Physician Referral ___University Hospital (UIHC) Website ___Word of Mouth
___ Brochure ___University Hospital Publication ___TV
___Radio Ad ___ Newspaper Ad ___Other:______________________

PERSONAL CONTACT INFORMATION

Home phone number: ____________________ Work phone number: ___________________
Cell phone number: ____________________ e-mail address: ____________________________________
What is the best method to contact you during the normal work-day hours? _____________________________

DEMOGRAPHIC INFORMATION

What is your highest level of education completed: ___ High School ___College ___Graduate School

What is your occupation?________________________

Describe any religious practices or beliefs that influence your diet or health care ____________________
____

Do you live alone? Yes____ No____
Who lives with you? (name, age & relationship)
_________________ ___ __________________. _________________ ___ ___________________
_________________ ___ __________________. _________________ ___ ___________________

WEIGHT HISTORY : As you can best recall, what was your weight at these times in your life?

Age 5 ________ Age 20 _________ Age 50 + ______ Weight now? ____
Age 10 _______ Age 30 _________ Lowest (adult) weight? _____
Age 15 _______ Age 40 _________ Highest weight? _____

Have any of the following life events been associated with significant (approx 50 pound or more) weight change.
__ Marriage __ Having children __ Divorce/Break up __ Quit smoking
__ Starting college __ Changing jobs __ Retirement __Death in the family
__ Children leaving home __ Major illness/injury __ Start/End medication (especially antidepressants)
__ Other life event ______________________________

For women:
1st Pregnancy: weight gain_____ weight lost after pregnancy____ how long weight loss maintained?____ yrs.
2nd Pregnancy: weight gain_____ weight lost after pregnancy____ how long weight loss maintained? ____yrs.
3rd Pregnancy: weight gain_____ weight lost after pregnancy____ how long weight loss maintained? ____yrs.
4th Pregnancy: weight gain_____ weight lost after pregnancy____ how long weight loss maintained? ____yrs.

DIETARY BEHAVIORS

Many people try at one time or another to make changes in what they eat, to become more active, or to lose weight. Some people will find changes easy to make, and others will find them difficult. In the following sections, you will be asked about things you may have done in the past month to change your eating habits and activity level, or to manage your weight. There are no right or wrong answers so please just answer as best you can. Please answer every question by placing an X in the box.

Thinking about the past month, how often did you....

	Almost Never	Some-times	Often	Almost Always
1. Weigh yourself on a scale?				
2. Set goals related to your weight? (such as losing a certain number of pounds, or maintaining your current weight)				
3. Set goals related to your eating habits?				
4 Keep track in your head of what kinds of foods you have eaten during the course of the day?				
5 Keep track in your head of the amount of food you eat?				
6. Keep track in your head the amount of fat you eat?				
7. Try to keep track of the number of calories you have eaten?				
8. Adjust what you ate at a meal based on what you already ate that day?				
9 Adjust what you ate at a meal based on what you expect to eat later in the day?				
10. Praise yourself when you ate healthy foods?				
11. Reward yourself for eating healthy foods?				
12. Think about the benefits of eating healthy foods?				
13. Say positive things to yourself about healthy eating?				
14. Think about things that motivate you to eat healthier meals?				
15. Plan meals ahead of time?				
16. Eat less food during the day if you were attending a social event in the evening?				
17. Make out a grocery list and stick to it at the store?				
18. Read articles or brochures about how to lose weight?				
19. Read labels on food to check for nutrition information?				
20. Choose leaner meats over those higher in fat?				
21. Cut off visible fat from meat?				
22. Remove the skin from chicken?				

Again, thinking of the past month, how often did you…	Almost Never	Some-times	Often	Almost Always
23. Buy low-fat versions of dairy products?				
24. Limit high-fat extras such as butter, gravy, sauces, salad dressings?				
25. Choose small servings of high-fat foods?				
26. Stop eating when full?				
27. Refuse offers of food when you were not hungry?				
28. Try to limit the <u>number</u> of food servings you ate?				
29. Try to limit the <u>size</u> of food servings you ate?				
30. Try to find something else to do instead of snacking?				
31. Try to bring healthy foods to social events with family members or friends?				
32. When you go out to eat with family members or friends, suggest restaurants that have at least some healthy choices on the menu?				
33. Serve healthy foods when you have family or friends over?				

Below are some common eating patterns, please check those that apply to you:

__ I eat exactly the same things every day
__ What I eat during the week differs from what I eat on the weekends
__ I “graze” during the day
__ I eat three meals per day
__ I eat one or two meals per day
__ I tend to skip meals
__ I eat breakfast every day
__ I eat just before bedtime
__ I get up at night and eat in the middle of the night
__ I eat more rapidly than others around me
__ I eat large amounts of food when I am not feeling hungry
__ I eat alone most of the time
__ I eat alone because I am embarrassed by how much I eat
__ I feel disgusted, depressed or guilty after overeating
__ I feel that I don’t have the control to stop eating

How many times each day do you snack between meals? __ Rarely __ 1-2 times __ 3 or more times

When you snack, what foods do you usually choose? ____

Please list situations in which you might eat when you are not really hungry ___________________________

____

How many times each week do you eat out for the following meals? Breakfast____ Lunch____ Dinner____

What restaurants do you chose when eating out? (list 3)____

What do you usually drink with your meals? Breakfast __________Lunch _____________Dinner __________

How much water do you drink each day? ________

How much soda or pop do you drink each day? ____________cans/individual bottles

If you drink soda, do you usually drink diet or regular soda? _________

Do you drink alcohol? Yes _____ No_____

If you drink alcohol how often do you drink? ____ (times per week)

If you drink alcohol how much do you drink? _____ (drinks per day)

Who does the grocery shopping for your household? I do _____ Other (list) ___________________________
Who prepares most of your meals? I do _____ Other (list) ________________
Are there household members who have different eating preferences or habits than yours? Yes____ No_____
If yes, please describe these different preferences:____
____

Check the situation that is most typical for you for most meals
__ Eat seated at a table ___ times per week
__ Eat in front of TV or computer ___ times per week
__ Eat standing up/on the run ___ times per week

Are you happy with your present eating pattern? ___________
If you think you need to change what you eat or how you eat, what two changes would you like to make?
(1) ____
(2) ____

Think back over the past 24 hours as to what you have eaten. List what you ate and drank, and the times if you can recall.
Yesterday for breakfast: ____
Midmorning snack: ____
Yesterday for lunch: ____
Mid-afternoon snack: ____
Yesterday dinner: ____
Evening snack: ____

Please list any programs or medications that you have tried in the past to lose weight in the table below.

Name	Dates	Length of Participation	Maximum Weight Change	How long did you maintain weight loss?

Did you maintain weight loss for at least 1 year after finishing any of these programs? ___________________
What did you learn from these programs regarding your weight? ____________________________________
____
____
Why do you think you were or were not successful in keeping your weight off? _________________________
____
____

Have you counted calories before? yes _____ no _____
Have you kept food records before? yes _____ no _____
Have you met with a dietician before? yes _____ no _____ If so, did you find it helpful? _______

If helpful, what did you learn? ____

____

If not helpful, can you state any reasons that you found them unhelpful? ______________________

____

Do you think that you know enough about diet and nutrition at present?

Not at all 1 2 3 4 5 Definitely

Do you think that you are able to use the knowledge that you have about diet and nutrition at present?

Not at all 1 2 3 4 5 Definitely

PHYSICAL ACTIVITY

Thinking about the past month, how often did you...

	Almost Never	Some-times	Often	Almost Always
34. Set goals related to how much you exercise?				
35. Keep a record in your head of how physically active you've been during the week?				
36. Increase your level of physical activity for the day because you had not been very active in recent days?				
37 Increase your level of physical activity for the day because you expected to not be very active in the coming days?				
38 Find ways to work in some small amounts of physical activity during the day? (like taking the stairs instead of the elevator; walking instead of driving somewhere, etc)				
39. Suggest doing something active when you get together with family members or friends, such as going for a walk, biking, swimming, etc.?				
40. Set aside a special time to do physical activity?				
41. Ask a friend or relative to do some physical activity with you?				
42. Talk to others about the benefits of physical activity?				
43. Praise yourself for doing physical activity?				
44. Reward yourself for being physically active?				
45. Think about the benefits of being physically active?				
46. Say positive things to yourself about being physically active?				
47. Think about things that motivate you to be physically active?				

To what extent are you able to carry out the following daily activities?

Activity	Very Limited	Somewhat Limited	Not Limited
Getting in and out of bed without assistance			
Bathing and dressing yourself			
Personal hygiene/toileting			
Climbing several steps			
Climbing one flight of steps			
Climbing 2 or more flights			
Rising from a soft/low seat			
Walking within your home			
Walking less than 1 block			
Walking, several blocks			
Walking more than one mile			
Lifting and carrying groceries			
Moderate household tasks (moving furniture, vacuuming, scrubbing floors, mowing the lawn, gardening)			
Tasks that require bending, (stooping, kneeling)			

What is the most common physical limitation you have in your daily activity? ______________________________

____

Do you use any special equipment for mobility? (Check all that apply):

__ Cane __ Prescription shoes __ Wheelchair __ Walker __ Brace (back)
__ Crutches __ Brace (leg) __ Hospital Bed __ Lift Chair __ None

Do you participate in regular cardiovascular exercise (ie walk bike swim) yes _____ no ______
If so, what do you do and how often (ie daily weekly)? ____

Do you participate in regular resistance training exercise (ie weights) yes _____ no ______
If so, what do you do and how often (ie daily weekly)? ____

Do you participate in sports or recreational activities? yes _____ no _____
If yes, please list: ____

How satisfied are you with your ability to be physically active? (Circle)

1	2	3	4	5
Very unsatisfied		Neutral		Very satisfied

Have you ever been told that you have a condition for which you should NOT exercise? ___________________
If yes, what is that condition?____

What limits your ability to be more physically active? ____

What activities would you like to be able to do better (activities you were once able to do but no longer can, due to your current health and physical limitations):
List some or all:____

What is the most physically active thing you do during the week?_______________________________________

If you could chose any physical activity that you would like to be able to do, what would it be?

____

____

HEALTH HISTORY: Please CHECK all current or past conditions that apply to you:

__ asthma __ arthritis __ back pain __ blood clots __ urinary stress incontinence
__ depression __ cancer __ diabetes __ headaches __ sleep apnea (on CPAP)
__ emphysema __ fatty liver __gall stones __ stroke __ reflux disease (heartburn)
__ kidney disease __ seizures __ joint pains __ rashes __ high blood pressure
__ high cholesterol __ heart disease __ low testosterone __ menstrual problems
__ OTHER please list: ____

How do you rate your overall health? __Excellent ___Good ___Fair ___Poor __Severely ill

When did you last see your doctor? ___________ month/year
Please describe any specific concerns discussed: ______________________________
When did you last have blood tests done? ______________________________
Have you recently had any other tests done? If so, can you remember whether there were any abnormalities? (X-rays, CT scans, EKG, and so forth) ______________________________

____

What medications are you presently taking? (please write names from the prescription bottles, along with how you take the medicines.)

____
____
____
____

Are you presently taking any over-the-counter medicines, herbals or vitamins? If so, please list these:

____
____
____
____

Have you had surgery in the past? Please list type & date

____
____
____

The following section asks you to think about specific problems you might have. If a condition applies to you, please check the box and then make any comments you think we might find helpful. We may also ask you further questions during your visits at the clinic.

NEUROLOGICAL PROBLEMS

__ Seizures __ Headaches that impair your ability to fulfill activities in daytime
__ Stroke / TIAs __ Visual disturbances (double vision, blind spots, etc)
__ Unexplained dizzy spells
__ Other neurological (nerve or brain) symptoms, please describe: ______________________________

____

MENTAL HEALTH or ILLNESSES

__ History or current diagnosis of an eating disorder

- __ Compulsive overeating
- __ Binge eating disorder
- __ Anorexia nervosa
- __ Night time eating
- __ Bulimia (making yourself vomit after eating)
- __ Medications to control weight

__ Depression/symptoms of depression (low energy, lack of interest in usual activities, crying frequently, etc)?
Do you feel your weight is contributing to your depression? Yes ____ No _____
__ Anxiety or panic attacks
__ Bipolar disorder
__ Attention Deficit Disorder/Hyperactive Disorder Deficit
__ Ever had a problem with Substance Abuse or Addiction Previous____Current____
__ Problem with alcohol Previous___ Current____ How long off? _____
__ Problem with tobacco Previous___ Current____ How long off? _____
__ Problem with drugs (prescription or illegal) Previous___ Current____ How long off? _____
__ Ever been in counseling for any of these problems?
__ Other psychological symptoms, please describe ____

How would you rate your stress level? (Circle one) Low 1 2 3 4 5 High
Who helps support you during stressful times?____
How do you cope with daily stresses?____

HEART AND BLOOD VESSEL PROBLEMS

__ Hypertension (high blood pressure)
__ Heart murmur
__ Irregular heart beat
__ Chest pain
__ Ankle or feet swelling
__ Varicose veins
__ Blood clot (venous thrombosis)
__ Heart disease, heart attack, congestive heart failure
__ Other heart or blood vessel related symptoms, please describe____
____

LUNG /RESPIRATORY/PULMONARY DISEASES

__ Need to use supplemental oxygen, now?
__ Shortness of breath __ at rest __ lying flat __ walking
How far can you walk before you need to stop because of breathing problems?____________________
__ Smoke now?
If yes: number of cigarettes per 24 hours? ___________
Have you tried to quit? ___________
Have you quit for more than one month? ___________
__ Smoked nicotine products in the past? (cigarettes, cigars, pipes)
How long ago did you quit?________________________
__ History of pneumonia?
__ History of bronchitis
__ Troubled by a cough
__ Other breathing related symptoms, please describe ____

SKIN

__ Skin breakdown in skin folds (under abdomen, in groin, under breasts)
__ Skin infections (acne, boils, skin ulcers)
__ Other chronic skin rashes
__ Bruise easily
__ Abnormal hair growth on your face or body
__ Other skin related symptoms, please describe ____

SLEEP RELATED ISSUES

__ Been told that you snore?
__ Been told that you hold your breath or stop breathing when you sleep?
__ Wake up and feeling that you need to gasp for a breath?
__ Wake up with headaches?
__ Frequently fall asleep when you are reading?
__ Have daytime sleepiness?
__ Ever fallen asleep while driving or while stopped at a red light when you were driving?
__ Still feel exhausted even after at least 8 hours of sleep?
__ Ever had a sleep study?
If so, were you told that you have sleep apnea? ___________
__ Ever been told that you need to use a BiPAP or CPAP for sleep apnea?
If so, do you use it every night?___________
What is your average hours of sleep per night? ________ hours
Is your sleep restful? ___________
Do you have trouble falling asleep? Yes _______ No ______
Do you have trouble staying asleep? Yes _______ No ______
Have you ever tried sleep medications? ___________

GASTROINTESTINAL

__ Nausea or vomiting
__ Abdominal pain
__ Heartburn
__ Belching
__ Ulcer disease
__ Rectal bleeding
__ Hemorrhoids
__ Colonoscopy Date__________
__ Constipation
__ Diarrhea
__ Hernia
__ Gall bladder disease or gallstones
__ Celiac disease
__ Inflammatory bowel disease (Crohn's or UC)
__ Irritable Bowel Syndrome
__ Other intestinal symptoms, please describe ____

URINARY TRACT DISEASES

__ Difficulty passing urine
__ Difficulty holding urine so that you have incontinence
__ Recurrent bladder or kidney infections

FOR MEN:

__ History of enlarged prostate
__ History of prostate cancer
__ Difficulty having or sustaining an erection
__ Prostate exam (most recent)
Date__________

FOR WOMEN:

__ Post-menopausal
__ History of infertility
__ Trouble with sexual disinterest
__ Irregular menstrual cycles
__ Pap/pelvic exam Date__________
__ Bone Density Scan Date__________
__ Mammogram Date__________
Last normal period? Date__________
__ Other urinary or genital symptoms, please describe ____
____

BLOOD DISEASES

__ Sickle cell anemia or sickle cell trait
__ History of anemia ("low iron")
__ Other blood related symptoms, please describe ____

MUSCULOSKELETAL

__ Aching muscles
__ History of torn ligaments
__ Arthritis in my __Hands __Elbows __Shoulders __Feet __Knees __Hips
__ Back problems, please describe location in the back and any tests or therapy that you have had
____
____
__ Other symptoms related to your bones joints or muscles, please describe. ____________________
____

ENDOCRINE (GLANDULAR)

__ History of diabetes
__ History of thyroid disease
__ History of high cholesterol or triglycerides
__ History of gout
__ Other hormonally related symptoms, please describe ______________________________
____

OTHER

__ Any other physical or psychological concerns that you wish to discuss at this clinic visit, that are not covered in the questioning above. Please describe: ______________________________
____

HISTORY OF FAMILY ILLNESSES THAT CAN INFLUENCE YOUR HEALTH:

Has anyone in your family (including grand-parents, parents, uncles, aunts, brothers, sisters, children, grand-children, nieces and nephews) had any of the following problems? (check all that apply)

__ High blood pressure Who______________________________
__ High blood cholesterol Who______________________________
__ Diabetes mellitus Who______________________________
__ Cancer Who______________________________
Where was the Cancer? ______________________________
__ Thyroid disease Who ______________________________
__ Stroke Who ______________________________
__ Lung problems Who ______________________________
__ Liver problems Who ______________________________
__ Kidney problems Who ______________________________
__ Heart disease Who ______________________________
__ Overweight or Obesity Who ______________________________
__ Other:________________ Who ______________________________

For each of those relatives that have or had a problem with weight: please fill in the chart below.

Relative
Were/are they heavier than you?
Their approximate weight?
Did they have treatment for weight problem?
Did they have weight related health problems?

This is a fairly comprehensive questionnaire. However, we would like to provide the opportunity for you to tell us "your story". This should include what you consider the major reasons, such as significant life events, that have resulted in your weight problem. This is optional. PLEASE USE SEPARATE SHEET.

Please return questionnaires to: UI Weight Management. Attn: Marsha Kremer, E401-3 GH. University of Iowa Hospitals and Clinics. 200 Hawkins Drive. Iowa City, IA 52242.