



CARDINAL MEDICAL WEIGHT LOSS CENTER

INITIAL INTAKE QUESTIONNAIRE

Welcome to Cardinal Medical Weight Loss Center- A physician supervised weight management program.

Please take a few moments to answer the following questions. Your doctor will review these questions with you during your visit and you will have the opportunity to elaborate. Your answers will remain confidential as part of your medical record.

Patient Name _____ **Date** _____

A. What is the reason for you seeking weight loss?

Health Reasons

Special Event: _____

Cosmetic Reasons

Other _____

B. Weight History

How much did you weigh at birth? _____

What is your heaviest adult weight? (Excluding pregnancy)

What is your lowest adult weight? _____

When did you start to gain excessive weight? _____

C. Current Diet

List the types of food that you typically eat for breakfast

What time do you usually eat breakfast? _____

List the types of food that you typically eat for lunch

What time do you usually eat lunch? _____

List the types of food that you typically eat for dinner

What time do you usually eat dinner? _____

What type of snacks do you eat throughout the day?

Do you eat out at restaurants? Yes No

If yes,

How often do you eat out? Less than once a week
 Once a week 2-3 days per week
 3-5 days per week More than 5 days per week

Which restaurants do you go to?

Who shops for food in your household? _____

Do you use a shopping list? Yes No Sometimes

Who prepares your meals? _____

Do you have cravings for certain foods? Yes No

If yes, provide details _____

List any food allergies:

D. Exercise History

Do you exercise ? No Yes

List the type of exercise, duration and frequency per week:

E. Previous Weight Loss Attempts

Have you tried any diet programs in the past?

F. Please list your current medical conditions

G. List your current medication with dosage and frequencies

H. List all your allergies to food and or medications

I. Have you ever been diagnosed with an eating disorder ? No Yes

If so, what type ? _____

J. Have you ever been diagnosed with a psychiatric condition? No Yes

If so, what type? _____

K. Please list any medical conditions in your family:

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

L. WOMEN ONLY- GYN History

How many times have you been pregnant? _____

How many children do you have ? _____

Have you had any history of infertility ? _____

Have you had any irregular periods ? _____