The Foundation

HUMBOLDT-DEL NORTE FOUNDATION FOR MEDICAL CARE

A partner in the delivery of medical care in Humboldt and Del Norte Counties since 1963

Weight Management Lifeskills Program
Nutrition Initial Self-Assessment

Patient Name:_____ Age:_____

Referring Physician:_____

Registered Dietitian Signature:_____

Medical History

Do you have now or have you ever had any of the following medical problems?

Explain in the space.

- ❑ Diabetes
- ❑ Sleep apnea
- ❑ Arthritis or degenerative joint disease
- ❑ Hypertension (high blood pressure)
- ❑ Gastro esophageal reflux disease or frequent heartburn
- ❑ Edema (swelling of the legs, ankles)
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Depression treated with medication or counseling
- ❑ Anxiety
- ❑ Psychiatric illness
- ❑ History of physical or sexual abuse
- ❑ Alcoholism
- ❑ Substance abuse
- ❑ Eating disorder (anorexia nervosa or bulimia nervosa)

Medications and Allergies

List below all of the medications you take including those which do not require a prescription.

Medication	Dosage/amount	# of times taken daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Family History

Do any of your blood relatives have the following problems?

- Diabetes
- Heart disease
- Alcoholism

List the approximate weights of all family members (normal and overweight)

Maternal grandmother_____ Paternal grandmother_____

Maternal grandfather_____ Paternal grandfather_____

Mother_____ Father_____

Sister(s): _____ _____ _____ _____ Brother(s):

_____ _____ _____ _____

Child(ren): _____ _____ _____ _____

_____ _____ _____ _____

Diet and Weight History

Please check any of the following methods you have used in the past to lose weight

- □ Bingeing and purging
- □ Bingeing followed by food restriction
- □ Vomiting/Laxatives
- □ Diuretics

What is your lifetime maximum weight? _____ When? _____

Were you obese before puberty? Y/N

Do you feel that you are overweight because: (check all that apply)

- ❑ I eat normal amounts of food but have an abnormal metabolism.
- ❑ I eat larger than normal amounts of normal foods.
- ❑ I eat larger than normal amounts of normal foods as well as sweets and snacks.
- ❑ I tend to eat sweets and high calorie snacks.

Other: _____

Fill out the time line of weight during your life as best you can. Please include any important personal events, i.e. pregnancy, marriage, etc.

Age	Maximum weight	Important events
0-13		
13-18		
18-30		
30-50		
50+		

As a child/teen/adult, did you get pressure from family or friends to lose/gain weight? Y/N

Social History

With whom do you live?

Who does the shopping and cooking in the home?
What is your occupation?

How many hours per day do you watch TV?

What hobbies do you have that are important to you?

What do you do for relaxation?

Current Habits

How many carbonated beverages do you drink a day? _____Diet/Regular

How many times per week do you eat out? _____In a fast food restaurant? _____

How much water do you drink per day? _____

How much milk do you drink per day? _____skim/1%/2%/whole

How many cups of coffee do you drink per day? _____Decaf/Regular

Do you drink alcoholic beverages? Y/N Describe weekly intake_____

How many meals per day do you eat?_____

Do you snack? Y/N Describe_____

Do you eat in the middle of the night?_____

How many calories do you think you eat per day?_____

Exercise

Do you exercise? Y/N

If yes, please describe

If not, what is the most strenuous physical activity that you do in a week?

Which of the following activities can you do without stopping to rest?

- ❑ Walk to a building from a distant parking space
- ❑ Climb one flight of stairs
- ❑ Climb two flights of stairs
- ❑ None of the above

If you stop to rest; what are the main reasons you stop? (check all that apply)

- ❑ Short of breath/ Chest pain
- ❑ Fatigue
- ❑ Joint discomfort – circle which ones: hip knee ankle
- ❑ Back pain
- ❑ Other _____