**Weight Management Checklist**

On a scale of 1-10 what level of importance do you give to losing weight with a professionally supervised weight loss method (circle one)

LEAST IMPORTANT 1-2-3-4-5-6-7-8-9-10 VERY/MOST IMPORTANT

What life events may have been associated with weight gain? _____

_____

What are the factors that you believe affect your weight? _____

_____

How is your daily life affected by your weight? _____

_____

What diets or treatments have you tried to lose weight? _____

_____

Are you ready to make changes in your lifestyle to lose weight? Yes or No

What do you think might prevent you from losing weight? _____

_____

Who does most of the cooking in your house? _____

Any special diet restrictions? Yes or No If yes, please comment_____

_____

What is your beverage of choice? _____

**List of Medication**

**Allergies:**

Do you have any medication allergies or sensitivities?

Do you have any food allergies or sensitivities?

Please list all prescription medications and supplements that you are currently taking.

| **Name of medication** | How many mg is each tablet? | How many tablets do you take each day? | How often do you take a dose? | Prescribed by whom? | Why do you take this medication? |
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Do you have Diabetes?

Type I Insulin-dependent (insulin injections only)

Type II Non-insulin-dependent (diabetic pills)

Type II Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored? Yes or No if so, how often? _____

If so by whom? _____

**SLEEP HABITS**

How many hours in a night do you sleep? _____

Do you snore? Yes or No

Do you ever wake up with a headache? Yes or No

Can your snoring be heard through a door or wall? Yes or No

Has anyone ever told you that you stop breathing at night? Yes or No

Have you ever been diagnosed with sleep apnea? Yes or No

Have you ever worn CPAP? Yes or No

Do you every fall asleep while driving or stopped at a light? Yes or No

Are you often tired during the day? Yes or No

## EATING HABITS

**Breakfast**
Do you have breakfast every morning? Yes, No, Sometimes, Never
Approximate time: _____
Please give an example of what you have for breakfast. _____
_____
Do you have a snack before lunch? Yes, No, Sometimes, Never
Approximate time: _____
Examples: _____

**Lunch**
Do you have lunch every day? Yes, No, Sometimes, Never
Approximate time: _____
Examples: _____
_____

Do you have a snack before dinner? Yes, No, Sometimes, Never
Approximate time: _____
Examples: _____

**Dinner**
Do you have dinner every day? Yes, No, Sometimes, Never
Approximate time: _____
Examples: _____
_____

Do you have a snack at night? Yes, No, Sometimes, Never
Approximate time: _____
Examples: _____

**Activity log**

What activities do you enjoy? _____

_____

Do you exercise? Yes, No, Sometimes, Never, If yes, how? _____

_____

**Weight Loss Goals**

Dream goal_____

Short term goal_____

Goal date_____

Long term goal_____

Goal date_____

As a patient what do you think our medical staff can do to assist you in your weight loss program_____?

_____

Any questions I didn't ask that you wanted me to ask? _____

_____