



**KAISER PERMANENTE®**

# Medical Weight Management Program Pre-Program Questionnaire

In order to assist you in the difficult endeavor of weight management, we need certain information. We keep all information confidential and only use it to determine what additional support, if any, may be helpful to you.

_____	_____
Name	Date
_____	_____
Address 1	Medical Record Number
_____	_____
Address 2	Phone Number
_____	_____
	e-mail

## BACKGROUND

- Sex:  Female  Male Height (w/o shoes) \_\_\_\_\_ Weight: \_\_\_\_\_
- Occupation: \_\_\_\_\_ Age: \_\_\_\_\_
- Name of Primary Care Physician: \_\_\_\_\_ Facility: \_\_\_\_\_

4. On a scale of 1 to 10, how satisfied are you with your current employment? (circle one)

[.....]

1    2    3    4    5    6    7    8    9    10

Very Dissatisfied Very Satisfied

- This is my \_\_\_\_\_ attempt at losing weight with a meal replacement diet.
- What is the largest amount of weight you've ever lost? \_\_\_\_\_ lbs
- How long did you go before starting to regain? \_\_\_\_\_ months/years
- What reasons may have contributed to your weight regain?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. What is the most you have ever weighed?  
\_\_\_\_\_ lbs. at \_\_\_\_\_ yrs. old

10. What is the lowest weight, after age 21, which you maintained for at least one year?

\_\_\_\_\_ lbs. at \_\_\_\_\_ yrs. old

11. Have you ever had any significant physical symptoms or emotional reactions while attempting to lose weight or after losing weight?

Yes  No

If yes, please describe your symptoms or reactions, when they occurred, and the type of professional help you sought if any.

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12. Have you ever been treated by a psychiatrist and/or psychologist?

Yes  No Dates of Treatment: \_\_\_\_\_

13. How did you hear about this program? \_\_\_\_\_

- |                                                            |                                                              |
|------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Program brochure                  | <input type="checkbox"/> Friend/family member                |
| <input type="checkbox"/> Medical Weight Management website | <input type="checkbox"/> Your primary care provider          |
| <input type="checkbox"/> Mailed marketing materials/letter | <input type="checkbox"/> Medical Weight Management physician |
| <input type="checkbox"/> In-facility flyers/posters        | <input type="checkbox"/> Other physician                     |
| <input type="checkbox"/> Word of mouth                     | <input type="checkbox"/> Other (specify: _____)              |

14. Why did you choose this program?

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## PERSONAL HEALTH

Please list your health problems/health diagnoses

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## CURRENT MEDICATIONS

Please list your current medications (prescription and non-prescription)

Name	Strength	How Often	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



