Cayuga MEDICAL CENTER
A Member of Cayuga Health System
CAYUGA CENTER FOR HEALTHY LIVING

Health and Lifestyle Questionnaire

Name _____ **Date of birth** _____

Today's date_____ **Clinic visit date** _____

Please tell us the reason for your visit _____

_____

Weight history

Desired or goal weight ____ Height_____ Lowest adult weight ____ When? _____

Highest adult weight (non-pregnant) ____ When? _____

If you are overweight, when did you begin gaining excess weight?

- ○ Starting a new job
- ○ After High School
- ○ After College
- ○ After getting married
- ○ After having children
- ○ After surgery/injury
- ○ Other _____

Please list weight loss programs, diets, or medications you have tried, with approximate dates:

DIET	START DATE	END DATE
Atkins		
LA Weight Loss		
Cambridge		
Jenny Craig		
Medifast		
Nutrisystem		
Optifast		
TOPS		
South Beach		
Weight Watchers		
Other:		
Other:		

Maximum weight lost on any program _____

Eating pattern

Where are most meals eaten?

- At home alone
- At home with family
- At home with a friend
- At restaurants alone
- At restaurants with family
- At restaurants with a friend

Where do you purchase or obtain food? _____

Do you receive SNAP Benefits? Yes ___ No ___

Do you have food allergies or intolerances? _____

Any household special dietary restrictions? _____

Who usually cooks? _____ Who grocery shops? _____

Favorite foods _____ Food dislikes _____"Problem foods" _____

What percent of the time do you spend thinking about food and your weight? _____

Are you uncomfortable with how much you eat? Yes ___ No ___

Do you eat differently when you are alone? _____

Do you have difficulty chewing? Yes ___ No ___ Do you have trouble swallowing? Yes ___ No ___

Do you wear dentures? Yes ___ No ___ Do you have difficulty swallowing pills? Yes ___ No ___

If you are overweight, what are some reasons?

- Low level of physical activity
- Eating/snacking too many times daily
- Amounts of food eaten
- Kinds of foods eaten
- Eating out too often
- Lack of knowledge
- Eating too fast
- Social events
- Irregular meal and snack times
- Eating due to boredom or stress
- Lack of other satisfactions
- Overeating when alone
- Using food as reward or comfort
- Love the taste of food

Any eating problems?

- Anorexia nervosa
- Binge eating
- Bulimia
- Induced vomiting
- Laxative abuse
- Waking at night to eat
- Other _____
- None

Emotions associated with eating?

- Anger
- Anxiety
- Boredom
- Control
- Depression
- Enjoyment
- Hunger
- Guilt
- Stress
- Other _____

Do you think you are currently undergoing a stressful situation? Yes ___ No ___

If yes, please explain: _____

Activity and exercise

Previous activity/exercise _____

Current activity/exercise _____

Do you have any of these physical limitations?

- Chest discomfort
- Dizziness
- Joint swelling
- Back pain
- Foot pain
- Joint pain
- Knee pain
- Leg pain
- Muscle pain
- Shortness of breath
- Torn ligaments

Tobacco use

- Never
- Former : Type _____ Amount _____
- Current: Type _____ Amount _____

Start Date_____ Stop Date_____

Are you exposed to second hand smoke? Yes ___ No ___

Food pattern

How often do you have the following foods and beverages?

	Daily	Weekly	Seldom	Never
Milk, Yogurt				
Vegetables				
Fruit				
Red Meat				
Poultry				
Fish				
Sweets				
Regular soda				
Fast or fried food				

How would you describe the size of your servings?

- Small
- Average
- Large

How much tea, coffee, or other caffeinated beverages do you consume? _____

What other beverages do you drink? _____

Please jot down what you eat and drink on a typical day, if you have not been keeping a food record. If you never have a "typical" day, please write down what you ate yesterday:

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snack _____

The following three questions are for bariatric patients only—others please continue below.

1. *What kind of surgery are you interested in?* _____
2. *What type of exercise do you plan to do when recovered from surgery?* _____
3. *Please check how your partner, spouse, family, friends, or employer feel about your planned surgery:*

	Very critical	*Neutral*	*Supportive*	*Not applicable*	*Does not know*
Partner/spouse					
Family					
Friends					
Employer					

ALL—continue here. Please indicate whether your medical history includes any of these problems:

YES	NO	PROBLEM	COMMENTS
		Anxiety	
		Cancer	
		Diabetes	
		Depression	
		Difficulty breathing	
		High blood pressure	
		High cholesterol	
		Heart disease	
		Mental illness	
		Obesity	
		Osteoarthritis	
		Osteoporosis	
		Rheumatoid arthritis	
		Sleep apnea	
		Stomach/digestive problems	
		Stroke	
		Thyroid disease	
		Other	

WOMEN ONLY—do you have menstrual periods? Yes ___ No ___

If yes, how frequent are your periods?

How long do they last? _____

How heavy are they? _____

What do you use for contraception? _____

If no, please check reason:

- Hysterectomy
- Menopause
- Other _____

Do you have any leakage of urine when you cough, sneeze or exercise? Yes ___ No ___

ALL—continue here:

Surgeries and medically related events (for example: appendectomy, heart attack):

SURGERY OR MEDICAL EVENT	DATE

Family history

Please indicate who in your family has had these problems (include parents, grandparents, siblings and children)

YES	NO	PROBLEM	FAMILY MEMBER(S)
		Cancer – type	
		Diabetes	
		High Blood Pressure	
		High Cholesterol	
		Heart Disease	
		Mental illness	
		Obesity	
		Osteoarthritis	
		Osteoporosis	
		Rheumatoid arthritis	
		Stroke	
		Thyroid disease	
		Other	

Medications and supplements

Please list any prescription and non-prescription medications you are taking. If you have a current list, please bring it with you instead of filling this section out.

MEDICATION/SUPPLEMENT	DOSE	MEDICATION/SUPPLEMENT	DOSE

Allergies

Please list any drug or food allergies or intolerances, and what symptoms you have _____

_____

Are you allergic to latex? Yes ____ No ___

Social history

What is your occupation? _____

Current employment status? _____

Who lives in your household? _____

Relationship status? _____

How much do you sleep each day, on average? _____ Usual bedtime _____ Usual wake-up time _____

Alcohol intake: None ____ Number of drinks on occasion ____ Number of days per week you drink _____

Recreational drugs: Yes ___ No ___