Medical ASSOCIATES OF DAVIE
AT HILLSDALE

NOW! Weight Management Program Member Survey

CONFIDENTIAL

Please fill out this survey so we can best help you. All your answers will be kept private. Your answers will help us find you the best method for you to achieve a healthy weight.

Date: _____ Chart Number: _____ (Office Use)

Name: _____ DOB: _____

Personal

1. What do you do for a living? : _____

2. On a scale of 1 to 10, how happy are you with your current Job?
(10 being very happy)

1 2 3 4 5 6 7 8 9 10

3. What is the most you have ever weighed?
(For women, write in this weight when you were not pregnant.)
_____Lbs. at_____ years old

4. What is the lowest weight, you have been at for at least one year?
(This should be after 21 years of age.)
_____Lbs. at_____years old

5. Is there any time in your life for which you have no memory?
Yes No When:_____

6. Please fill in the following as best you can. Most people have tried diets in the past. Please tell us your answers for the ones you have tried.

Type of Diet/Program	**When did you try this program?**	**How long were you in this program?**	**How many pounds did you lose?**	**How long did you keep the weight off?**
Low Calorie Diet				
Protein Diet				
Weight Watchers				
Overeaters Anonymous				

Obesity/Diet Center Diet Pills				
Herbal Diet Pills				
Physician supervised fast				
Slim-Fast				
Nutrisystem				
Low-Carb Diet				
Injections				
Other:				

7. Can you accept compliments about your weight loss?
   Yes No

8. Can you accept compliments from the opposite sex?
   Yes No

9. How do you think your life will change if you lose weight?

10. Do you smoke cigarettes?
    Yes No
    a. How many cigarettes (packs) per day?_____

11. Think about how often you drink beer, wine or mixed drinks. Which is true?
    Fill in ( ) *one answer only.*
    - o I never drink any alcohol.
    - o I seldom drink more than 8 drinks per week
    - o I often drink more than 8 drinks per week.
    - o I binged in the past three months. (I drank more than three drinks in three hours.)

12. Think about the availability of drugs today. Which is true?
    Fill in ( ) *one answer only.*
    - o I never tried any illegal drugs.
    - o I experimented in the past but no longer use.
    - o I enjoy drugs only at an occasional party.
    - o I use drugs often.
    - o I have a problem with drugs now.

Eating Habits

13. What did you eat yesterday? Is this representative of a normal day?

14. Do you eat breakfast?

15. When eating at home, does your family routinely eat while watching the TV?

16. How often do you eat out each week?

17. How often do you eat fruits and vegetables as part of a meal?

18. What sort of snacks do you keep around the house?

19. How many sodas or sweetened beverages do you drink each day?

20. Do you know how to read nutrition labels?

21. a. After eating, have you ever forced yourself to vomit?
Yes No

b. Have you ever had a problem with binge eating?
Yes No

22. Answer this question if you answered yes to question 13a or 13b.
Do you recall the feelings that caused these actions? If so, tell us what you were feeling. Also write down the last time you did vomit or binge.

a. Vomiting

b. Binge eating

23. Do you use diuretics or laxatives now to help control your weight?
Yes No

Physical Activity

24. Do you get any physical activity now ?
(This might be walking, swimming, housework, gardening, exercise classes.)
Yes No

24(a). If yes, please write in below the activities you do. Also write down the number of minutes and the number of times each week for each one.
Type of Activity _____ # minutes _____# times/wk _____
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Type of Activity _____ # minutes _____# times/wk _____
Type of Activity _____ # minutes _____# times/wk _____

24(b). If you are not physically active on a regular basis are you willing to start an exercise program? (please circle one)

Yes No Maybe

25. What prevents you from exercising more?

Fill in ( ) *one answer:*

- I think I **do** get enough exercise.
- I have no time.
- My health is not good (such as asthma, arthritis, etc.).
- The neighborhood is too unsafe to be outside.
- We cannot afford gym memberships.
- I do not have anyone to keep me encouraged.
- I do not think that exercise is important.
- Other _____.

26. How many hours of television do you watch each day?

27. How many hours do you spend on the computer each day?

28. How often do you get outside for physical activity? Is it safe to do so in your neighborhood?

29. How often does your family do something active together? What might that include?

30. How easy is it to exercise during your work day?

Family and Childhood History

31. Are any of your family members obese? If yes, please circle those members who are obese.

Father
Mother
Sister(s) (note number) ____
Brother(s)(note number) ____
Father's side: Grandmother Grandfather Aunts Uncles
Mother's side: Grandmother Grandfather Aunts Uncles

32. Does anyone in your family have a history of:

- Diabetes
- Coronary heart disease
- Hypertension
- High Cholesterol
- Cancer

- Genetic disorder

33. How do you describe yourself?
    - Asian
    - Black
    - Caucasian
    - Hispanic
    - Native American
    - Other _____

34. Who lives with you in your home? Tell us their relationship if it is not obvious.

35. Who will support your efforts to lose weight?_____

36. Who will hinder your efforts to lose weight?_____

37. Do you have someone with whom you share your innermost thoughts and feelings?
    Yes No
    If yes, who? _____

38. Think about the family in which you were raised. Check the words that best describe it.
    - warm
    - distant
    - cruel
    - battling
    - destructive
    - loving
    - uninterested
    - rigid

39. How do you think how you were raised affected you?

40. Were the people who raised you (answer yes or no to each item).
    - Concerned about your worries? Yes No
    - Interested in how you did in school? Yes No
    - Made you feel wanted? Yes No
    - Often, critical of you? Yes No
    - Interested in who your friends were? Yes No
    - There if you needed help or support? Yes No

41. Were you raised by both of your biological parents?
    Yes No

42. How has this affected you?

43. Have you ever been sexually molested?

Yes No

44. If yes, how old were you at the time? _____.

45. How has this affected you later in life?

Stress in Your Life:

46. Read each of the items below. Please circle if you are currently experiencing stress in your life related to any of them.

A. work	F. legal/financial trouble
B. health	G. school
C. spouse – friend	H. moving
D. children	I. jealousy or infidelity
E. parents	J. other

47. What do you think is the cause of your weight problem?

48. How much would you like to weigh? _____Lbs.

49. Please use the space below to tell us anything else you think is important in understanding your weight problem or your successful participation in the program

Signature _____