

BARTELS MEDICAL ASSOCIATES, PLLC

MEDICAL WEIGHT CONTROL

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Name: _____ Home Phone: _____

Address: _____ Office Phone: _____

Birthdate: _____ Age: _____ Height: (no shoes) _____ Present Weight: _____

Desired Weight: _____ Birth Weight: _____ Weight at age 20: _____ Weight 1 year ago: _____

Occupation: _____ Physical Activity at Work: _____

Physical Activity at Home: _____

Sports and Athletic interests: _____

Describe any Medical Problems: _____

Past diets you followed-type? _____

Results? _____

Food Allergies: _____ Food Dislikes: _____

Other Allergies: _____ Who plans meals? _____ Cooks? _____

Shops? _____ Shopping list used? _____ How often do you eat out? _____

Do you drink alcohol? _____ What? _____ How much daily? _____ Weekly? _____

Describe usual energy level: _____ Foods you crave? _____

When? (time of day) _____ Do you awaken hungry at night? _____

What do you do? _____ What are your worst food habits? _____

Please describe your general health goals & the improvements you wish to make: _____

*Please turn over and complete back

Family Members
(relationship)

State of Health

Overweight?
No, Slight, Moderate, very

Typical Breakfast

Typical Lunch

Typical Dinner

Time Eaten:

Time Eaten:

Time Eaten:

Where: (Home,
Café, etc.)

Where:

Where:

With Whom:

With Whom:

With Whom:

Snack Habits: What?

How Much?

When:

Why did you have each snack at the time? (hunger, boredom, coffee break, etc.)
Please use your own words when answering this: