THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Welcome to the OSU Comprehensive Weight Management Program

Thank you for your interest in our programs. We are pleased that you are ready to make this a healthy year!

Program of interest:

- ❑ **Living Well**
- ❑ **Healthy Living**

Please complete the enclosed questionnaire and return by mail to:

OSU Comprehensive Weight Management
Attn: Kelly Urse
2050 Kenny Rd. Suite 1066
Columbus, Ohio 43221

OR fax to 614-366-2727

OR email to CompWeightManagement@osumc.edu

Once we receive your completed questionnaire, you will be contacted to schedule your initial appointment.

Patient Questionnaire

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

If you need help completing this form, please contact our office at 614-366-6675.

The Comprehensive Weight Management programs are confidential programs provided to promote healthy living. This means we will keep your information private and not share it with others unless you ask.

Information given by you in this questionnaire will be reviewed by a health care professional at your visit. There may be a need for a follow up visit to design a program personalized for you. You may not receive counseling on all issues at your initial consultation.

I wish to participate voluntarily in the initial evaluations to determine my health risks. I authorize a health care professional to measure my height, weight, blood pressure and resting metabolic rate. I understand this evaluation is not a substitute for a full examination by a physician. I agree to follow up with my physician on any high risk areas as discussed. If you do not have an established physician, please let us know. In addition, I understand that this questionnaire is not being used as a tool for the diagnosis and treatment of mental health disorders. This evaluation is not a substitute for an assessment by a licensed mental health provider. Participants are encouraged to work with Behavioral Medicine for any mental health concern.

I consent to the use of my exam and test results exclusively for group or statistical reports that protect my personal confidentiality.

Date: _____

Signed: _____

Name: _____

Home address: _____

_____

Phone: (work) _____ (home) _____ (cell) _____

Email: _____

Date of birth: _____ **Age:** _____

Learning Styles

1. Are there any traditions, beliefs and/or cultural practices that we need to know to assist us in your care?

   ❑ Yes ❑ No

   If yes, please describe: _____

   _____

2. How often do you need to have someone help you when you read instructions, pamphlets or written materials from your doctor or pharmacy?

   ❑ Always ❑ Sometimes ❑ Never

3. How confident are you in your ability to follow the label on a medicine bottle?

   ❑ Very confident ❑Somewhat confident ❑ Not at all confident

4. Have you ever had trouble hearing someone speak or had ringing in your ears?

   ❑ Yes ❑ No

   If yes, how long have you had this problem?

   ❑ Last six months ❑ Past year ❑ More than a year _____

5. Select which font size is the **<u>smallest</u>** that you can read easily.

   Big ❑ Bigger ❑ Biggest ❑

In the table below are major reasons that some patients use to seek weight loss. Rank each sentence 1 through 7 using this scale:

1 2 3 4 5 6 7

Most important reason Least important reason

Reason	Statement	My Score
Appearance	I am distressed or embarrassed by my physical appearance and need to improve it.	
Medical Condition	I want to improve my medical conditions associated with obesity.	
Physical Fitness	I lack physical fitness and want to be more active to enjoy life more.	
Health Concerns	I am concerned that my health will deteriorate (get worse) and my life may be shortened.	
Physical Limitation	I feel that my physical limitation of obesity makes day to day living very difficult.	
Employment	I want to enhance my employment prospects.	
Advice of others	I have been advised by others to have surgery for my weight problem.	

Dixon, JB., Laurie, CP, Anderson, ML, Hayden, MJ, Dixon, ME., & PE O'Brian. (2009) Motivation, readiness to change and weight loss following adjustable gastric band surgery. *Obesity, 17 (4), 698-705.*

Patients are asked to number these statements from the most important or appropriate (1) to the least important or appropriate (7) in regard to their reasons for seeking a surgical solution to their weight problem. This method is very familiar to Australians as this is the method used for electing politicians.

On a scale of 1 (not confident) to 10 (highly confident), how confident are you that you can meet your weight goal?

_____

On a scale of 1 (not motivated) to 10 (highly motivated), how motivated are you to meet your weight goal?

_____

Readiness to Change

Weight Loss Behavior – Stage of Change Scale

Instructions: Using the following as a guide, indicate which statement best describes you at the present time for each of the eating and activity behaviors listed in the table on the next pages.

I do NOT do this at least half the time now

1. ...and I have no plans to do this.
2. ...but I'm thinking about doing it sometime within the next 6 months.
3. ...but I'm making definite plans to start doing this within the month.

I do this at least half the time now and

4. ...I just started doing this within the last 6 months.
5. ...I have been doing this for more than 6 months.

Eating and Activity Behaviors	No plans	Thinking about it	Definite plans to begin	Started doing	Doing for 6+ months
	1	2	3	4	5
Portions					
1. Limit how much you eat so you don't eat more calories than you need.	☐	☐	☐	☐	☐
2. Weigh and measure your portions of food.	☐	☐	☐	☐	☐
3. Eat less at a later meal if you've splurged earlier.	☐	☐	☐	☐	☐
4. Stop eating before you feel stuffed.	☐	☐	☐	☐	☐
5. Avoid eating when you're nervous, upset, or depressed.	☐	☐	☐	☐	☐
6. Drink a glass of water before a meal.	☐	☐	☐	☐	☐
7. Resist eating everything on your plate if you're no longer hungry.	☐	☐	☐	☐	☐
8. Keep track of how much you're eating when you snack.	☐	☐	☐	☐	☐
9. Say "No" to second helpings.	☐	☐	☐	☐	☐

Eating and Activity Behaviors	No plans	Thinking about it	Definite plans to begin	Started doing	Doing for 6+ months
	1	2	3	4	5
Dietary Fat					
1. Eat a low fat diet.	☐	☐	☐	☐	☐
2. Eat chicken and turkey without the skin.	☐	☐	☐	☐	☐
3. Eat low fat dairy products such as skim or 1% milk, low fat yogurt, and low fat cheese.	☐	☐	☐	☐	☐
4. Trim all the fat off all meat.	☐	☐	☐	☐	☐
5. Limit your meat portions to 3 oz per meal (the size of a deck of cards).	☐	☐	☐	☐	☐
6. Avoid deep fried foods such as fried chicken and french fries.	☐	☐	☐	☐	☐
7. Avoid fast foods such as burgers and fries or tacos.	☐	☐	☐	☐	☐
8. Avoid snacks such as regular potato chips, corn chips, and peanuts.	☐	☐	☐	☐	☐
9. Leave off butter and margarine from bread, rolls, muffins, or bagels.	☐	☐	☐	☐	☐
10. Avoid baked goods such as cake, cookies, pies, donuts & pastry.	☐	☐	☐	☐	☐
11. Use low fat salad dressing.	☐	☐	☐	☐	☐
Fruits and Vegetables					
1. Eat at least 5 servings of fruits and vegetables per day.	☐	☐	☐	☐	☐
2. Eat at least 3 servings of green vegetables such as broccoli, green beans or spinach every day.	☐	☐	☐	☐	☐
3. When given a choice, pass up the fries and order the vegetables instead.	☐	☐	☐	☐	☐
4. Eat at least 2 servings of fruit every day.	☐	☐	☐	☐	☐
5. Eat salads with mixed greens and vegetables such as carrots or tomatoes.	☐	☐	☐	☐	☐
6. Add fruit to your dishes such as bananas to cereal or melon to cottage cheese.	☐	☐	☐	☐	☐

Eating and Activity Behaviors	No plans	Thinking about it	Definite plans to begin	Started doing	Doing for 6+ months
	1	2	3	4	5
7. Eat fruit as a dessert.	☐	☐	☐	☐	☐
8. Add vegetables to dishes such as lettuce and tomatoes to sandwiches and extra vegetables to casseroles.	☐	☐	☐	☐	☐
9. Snack on fruit when you snack.	☐	☐	☐	☐	☐
Usual Physical Activity					
1. Include a lot of physical activity in your daily routine.	☐	☐	☐	☐	☐
2. Spend a lot of time away from your desk doing more active tasks at work.	☐	☐	☐	☐	☐
3. Do heavy housework, for example washing windows, scrubbing walls or floors or bathroom tiles.	☐	☐	☐	☐	☐
4. Do heavy work on the job, for example, lifting heavy objects or working with heavy machinery.	☐	☐	☐	☐	☐
5. Do outdoor work at home such as gardening, mowing a lawn (don't count a riding mower), raking leaves or shoveling snow.	☐	☐	☐	☐	☐
6. Look for small ways to be active in your daily routine such as not using the TV remote, answering the phone furthest away, or doing household chores by hand.	☐	☐	☐	☐	☐
7. Do active things in the evening (visit friends, take walks).	☐	☐	☐	☐	☐
8. Use stairs rather than elevators and escalators.	☐	☐	☐	☐	☐
9. Park your car away from the entrance at work and at the mall so you have to walk a distance.	☐	☐	☐	☐	☐

Appendix A: Weight Loss Behavior-Stage of Change Scale (WLB-SOC Scale)

Sutton, K., Logue, E., Jarjoura, D., Baughman, K., Smucker, W., & C.Capers. (2003). Assessing dietary and exercise stage of change to optimize weight loss interventions. Obesity Research, 11 (5), 641-652.

Which of these make your weight loss harder? Please mark all that apply.

- ❑ Lack of time
- ❑ Lack of energy
- ❑ Work schedule
- ❑ Responsibilities for caring for loved ones
- ❑ Emotional eating
- ❑ Stress
- ❑ Physical health concerns
- ❑ Other: _____

Weight and Diet History

1. At what age did you first start struggling with your weight? _____
2. At what age did you attempt your first diet? _____
3. Has your weight changed over the past year? ❑ No

   ❑ Yes, I gained _____ pounds, **or** ❑ Yes, I lost _____ pounds
4. What were your biggest difficulties following past diets?

   - ❑ Boredom
   - ❑ Life events
   - ❑ Too restrictive
   - ❑ Didn't suit needs
   - ❑ Too hungry
   - ❑ Financial
   - ❑ Too much of a time commitment
   - ❑ Other: _____
5. What about certain diets has worked for you in the past?

   - ❑ Professional guidance
   - ❑ Peer support
   - ❑ Simplicity
   - ❑ Fit lifestyle
   - ❑ Food journaling
   - ❑ Accountability
   - ❑ Structure
   - ❑ Addressed emotional/behavioral eating issues
   - ❑ Addressed exercise
   - ❑ Other: _____
6. Are you currently following a diet? ❑ No ❑ Yes: _____
7. Do you take laxatives or vomit to eliminate the food you've eaten? ❑ Yes ❑ No
8. What do you think is a realistic or an "okay" weight for you? _____ pounds
9. How long has it been since you were at that weight? _____

Nutritional Analysis

1. How many ounces of meat do you usually eat **per day**?

   3 ounces (oz) of meat, fish, or chicken is any ONE of the following: 1 regular hamburger, 1 chicken breast, 1 chicken leg (thigh and drumstick), 1 pork chop or 3 slices of lunch meat

   - ❑ I do not eat meat, fish or poultry
   - ❑ 3 oz or less per day
   - ❑ 4-6 oz per day
   - ❑ 7 or more oz per day

2. How much cheese do you eat **per week**?

   - ❑ I do not eat cheese.
   - ❑ I eat whole milk cheese once per week and/or use only low fat cheese such as diet cheese, low fat cottage cheese or ricotta.
   - ❑ I eat whole milk cheese, such as cheddar, Swiss, monterey jack, once or twice a week.
   - ❑ I eat whole milk cheese three or more times per week.

3. What type of milk do you use?

   - ❑ Skim, 1% or don't use milk
   - ❑ Usually skim or 1%, but occasionally others
   - ❑ 2% or whole milk

4. How many egg yolks from whole eggs do you use **per week**?

   - ❑ Less than one per week or use only egg substitute
   - ❑ 1-2 egg yolks per week
   - ❑ 3 or more egg yolks per week

5. How often do you eat regular hamburger, bologna, salami, hot dogs, corned beef, spare ribs, sausage, bacon or liver? Do not count other meats.

   - ❑ I do not eat any of these meats
   - ❑ About once per week
   - ❑ 2-4 times per week
   - ❑ More than 4 times per week

6. How many commercially baked goods and how much regular ice cream do you usually eat?
   - ❑ I do not eat commercially baked goods and ice cream
   - ❑ Once per week or less
   - ❑ 2-4 times per week
   - ❑ More than 4 times per week

7. What is the main type of fat you cook with?
   - ❑ Non-stick spray or no fat used in cooking
   - ❑ Liquid oil (safflower, sunflower, corn, soybean, olive oil)
   - ❑ Margarine
   - ❑ Butter, shortening, bacon drippings, or lard

8. How often do you eat snack foods such as chips, fries or party crackers?
   - ❑ I don't eat these snack foods
   - ❑ 1 serving per week
   - ❑ 2-4 servings per week
   - ❑ More than 4 servings per week

9. What spread do you usually use on bread, vegetables, etc.?
   - ❑ I do not use any spread
   - ❑ Diet or light margarine
   - ❑ Margarine
   - ❑ Butter

10. How often do you eat candy bars, chocolate or nuts?
    - ❑ Less than once per week
    - ❑ 1-3 times per week
    - ❑ More than 3 times per week

11. When you use recipes or convenience foods, how often are they low-fat?

- ❑ Almost always
- ❑ Usually
- ❑ Sometimes
- ❑ Seldom or never

12. When you eat away from home, how often do you choose low-fat foods?

- ❑ Almost always
- ❑ Usually
- ❑ Sometimes
- ❑ Seldom or never

13. During the past seven days, how many times did all, or most, of the people living in your household eat a meal together?

- ❑ I live alone
- ❑ never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times
- ❑ more than 7 times

14. Which of the following best describes your **daily** consumption of grain products?

- ❑ I eat 6 or more servings of whole grain products daily.
- ❑ I eat 6 or more servings of refined and/or whole grain products daily.
- ❑ I eat 3-5 servings of refined and/or whole grain products daily.
- ❑ I eat less than 3 servings of refined and/or whole grain products daily.

15. Which of the following best describes your **daily** consumption of vegetables?

- ❑ I eat 3-5 servings of vegetables daily.
- ❑ I eat 2-3 servings of vegetables daily.
- ❑ I eat 1-2 servings of vegetables daily.
- ❑ I only eat vegetables occasionally.

16. Which of the following best describes your **daily** consumption of fruits?

- ❑ I eat 3-5 servings of fruit daily.
- ❑ I eat 2-3 servings of fruit daily.
- ❑ I eat 1-2 servings of fruit daily.
- ❑ I only eat fruit occasionally.

17. Which of the following best describes your use of salt and seasonings?

- ❑ I regularly use salt substitutes, herbs, flavoring aids or use nothing instead of salt.
- ❑ I occasionally use salt to season food.
- ❑ I regularly season food with salt after tasting.
- ❑ I always use salt to season food without tasting first.

18. How many 8-ounce **calorie-free** beverages, including water, do you drink **per day**?

- ❑ More than 7
- ❑ 5-7
- ❑ 3-4
- ❑ 1-2
- ❑ Sometimes none

19. How many 8-ounce beverages **with caffeine** do you drink **per day**? _____

20. What other types of beverages (besides water) do you drink?

- ❑ Alcohol
- ❑ Sports drinks
- ❑ Regular soda
- ❑ Diet soda
- ❑ Juice
- ❑ Coffee
- ❑ Tea
- ❑ Flavored water

Emotional Eater Questionnaire

Questions	Never	Sometimes	Generally	Always
1. Do the weight scales have a great power over you? Can they change your mood?	☐	☐	☐	☐
2. Do you crave specific foods?	☐	☐	☐	☐
3. Is it difficult for you to stop eating sweet things, especially chocolate?	☐	☐	☐	☐
4. Do you have problems controlling the amount of certain types of foods you eat?	☐	☐	☐	☐
5. Do you eat when you are stressed, angry or bored?	☐	☐	☐	☐
6. Do you eat more of your favorite food and with less control when you are alone?	☐	☐	☐	☐
7. Do you feel guilty when you eat “forbidden” foods like sweets or snacks?	☐	☐	☐	☐
8. Do you feel less control over your diet when you are tired after work at night?	☐	☐	☐	☐
9. When you overeat while on a diet, do you give up and start eating without control, particularly the food you think is fattening?	☐	☐	☐	☐
10. How often do you feel that food controls you rather than you controlling food?	☐	☐	☐	☐

Garaulet, M., Canteras, M., Morales, E., Lopez-Guimera, G., Sanchez-Carracedo,D., & Corbalan-Tutau, M.D. (2012)

Validation of a questionnaire on emotional eating for use in cases of obesity; the Emotional Eater Questionnaire (EEQ). Nutr Hosp. 2012;27:645-651

Support, Lifestyle Behaviors

1. With whom do you live? Check all that apply.

   - ❑ No one, I live alone
   - ❑ Spouse/partner
   - ❑ Children: how many? _____ Ages: _____
   - ❑ Roommates
   - ❑ Parents
   - ❑ Other relatives: _____
   - ❑ Other (please specify): _____

2. If you are currently in a close relationship (spouse/partner), would this person support you as you make healthy lifestyle changes?

   - ❑ Strongly supports me
   - ❑ Supports me
   - ❑ Neutral
   - ❑ Opposes me
   - ❑ Strongly opposes me

3. Have you talked to your spouse/partner about making healthy lifestyle changes?

   ❑ Yes ❑ No

4. Who prepares meals in your home?

   - ❑ Self
   - ❑ Significant other
   - ❑ Spouse
   - ❑ Roommate
   - ❑ Child
   - ❑ No one
   - ❑ Other: _____

5. How many meals do you eat away from home per week? Include fast food, carry-out, delivery, sit-down, etc.

	Weekdays	Weekends
Breakfasts	_____	_____
Lunches	_____	_____
Dinners	_____	_____

6. List restaurants where you often eat. Include fast food, carry-out, delivery, sit-down, etc.

   _____

   _____

7. Do you currently take vitamins, minerals and/or other dietary supplements? ❑ No

   ❑ Yes: _____

   _____

8. Are you lactose intolerant? ❑ Yes ❑ No

Medical History

1. Do you have a primary care provider? ❑ Yes ❑ No

   If yes, do we have your consent to send a copy of your results to your primary care provider? ❑ Yes ❑ No

   If yes, please list provider's name: _____

   Please provide a complete address: _____

   _____

Medicine List (add additional sheet if needed)

Medicine including over the counter, supplements and herbals	Dose / Strength	How often (frequency)	Why do you take it?

Social History

Alcohol:

1. How many of the following do you drink per week?

   Mixed drinks (1 oz/drink) _____ Beer (12 oz) _____ Wine (6 oz glass) _____

2. Do you have a history of alcohol abuse? ❑ Yes ❑ No
3. Have you ever felt or been told that you have a drinking problem? ❑ Yes ❑ No

Psychological History

1. Have you ever been diagnosed with a mental health illness such as anxiety, depression, bulimia, etc.? ❑ Yes ❑ No

   If yes, please list diagnosis and treatment such as medicines, one-on-one therapy, etc.: _____

2. Are you currently being seen for mental health treatment? ❑ Yes ❑ No

   If yes, is weight management a focus of your treatment? ❑ Yes ❑ No

3. Do you believe that your weight issues are connected to your emotional health?

   ❑ Yes ❑ No

   If yes, how so? _____

   _____

4. Would you like to find a counselor or other professional for mental health treatment?

   ❑ Yes ❑ No

Stress and Well-Being

1. In general, how satisfied with life are you?
   - ❑ Mostly satisfied
   - ❑ Partly satisfied
   - ❑ Not satisfied

In a typical week, how often have you:	Never	Almost Never	Sometimes	Fairly Often	Very Often
2. Been upset because of something that happened unexpectedly?	☐	☐	☐	☐	☐
3. Felt unable to control the important things in your life?	☐	☐	☐	☐	☐
4. Felt stressed?	☐	☐	☐	☐	☐
5. Felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
6. Felt that things were going your way?	☐	☐	☐	☐	☐
7. Found that you couldn't cope with all the things you had to do?	☐	☐	☐	☐	☐
8. Been able to control irritations in your life?	☐	☐	☐	☐	☐
9. Felt you were on top of things?	☐	☐	☐	☐	☐
10. Been angered because of things that were beyond your control?	☐	☐	☐	☐	☐
11. Felt that difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

12. How many people (friends, relatives or counselors) do you have with whom you can talk honestly about your problems and concerns in your life?
   - ❑ 0
   - ❑ 1
   - ❑ 2
   - ❑ 3
   - ❑ 4 or more

Exercise

1. Mark one box only below that represents your current activity status. Read all choices before making your selection. **Do not include activities you do as a part of your job.**

   Vigorous exercise includes activities like jogging, running, fast cycling, aerobics class, swimming laps, singles tennis and racquetball.

   Moderate exercise includes activities like brisk walking, gardening, slow cycling, dancing, doubles tennis or hard work around the house.

   - ❑ I do not exercise or walk regularly now, and I do not intend to start in the near future.
   - ❑ I do not exercise or walk regularly, but I have been thinking of starting.
   - ❑ I am trying to start to exercise or walk. During the last month I have started to exercise or walk on occasion or on weekends only.
   - ❑ I have exercised or walked infrequently for over one month.
   - ❑ I have been doing moderate exercise, less than 3 times per week.
   - ❑ I have been doing moderate exercise, 3 or more times per week for 1-6 months.
   - ❑ I have been doing moderate exercise, 3 or more times per week for 7 months or more.
   - ❑ I have been doing vigorous exercise, 3-5 times per week for 1-6 months.
   - ❑ I have been doing vigorous exercise, 3-5 times per week for 7-12 months.
   - ❑ I have been doing vigorous exercise, 3-5 times per week for over 12 months.
   - ❑ I have been doing vigorous exercise 6 or more times per week.

2. How often do you do at least 10 minutes of resistance exercise to increase strength and muscle tone?

   - ❑ Rarely or never
   - ❑ 1-2 times per week
   - ❑ 3 or more times per week

3. How often do you do at least 5-10 minutes of stretching and flexibility exercises?

   - ❑ Rarely or never
   - ❑ 1-2 times per week
   - ❑ 3 or more times per week

Exercise Pre-participation Health Screening Questionnaire

Please mark all *true* statements.

Step 1: Signs and Symptoms

Do you currently experience:

- ❑ Chest discomfort with exertion
- ❑ Unreasonable breathlessness
- ❑ Dizziness fainting, blackouts
- ❑ Ankle swelling
- ❑ Unpleasant awareness of a forceful, rapid or irregular heart rate
- ❑ Burning or cramping sensations in lower leg when walking short distance
- ❑ Known heart murmur
- ❑ None of the above

Step 2: Medical Conditions

Have you been diagnosed with:

- ❑ A heart attack
- ❑ Heart surgery, cardiac catheterization, or coronary angioplasty
- ❑ Pacemaker/implantable cardiac defibrillation/rhythm disturbance
- ❑ Heart valve disease
- ❑ Heart failure
- ❑ Heart transplantation
- ❑ Congenital heart disease
- ❑ Diabetes
- ❑ Renal disease
- ❑ None of the above

Step 3: Current Activity

Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months?

- ❑ Yes
- ❑ No

If you **marked** any of the statements in Step 1 or Step 2, **STOP**, you should seek medical clearance before engaging in or resuming exercise. Please return the attached form signed by your physician**.**

If you did not mark any of the statements in Step 1 or Step 2, medical clearance is not needed.

This preparticipation screening form was developed for exercise professionals for use with ACSM's preparticipation screening algorithm, which can be found in *ACSM's Guidelines for Exercise Testing and Prescription,* 10th edition, 2017.

OSU Comprehensive Weight Management
2050 Kenny Rd.
Columbus, OH 43221
Phone: 614-688-9588
Fax: 614-366-2727

MEDICAL CLEARANCE FOR EXERCISE

PATIENT: _____ DOB: _____

I have cleared my patient to participate in an exercise program as part of the OSUWMC Comprehensive Weight Management program.

Signature of MD/DO/NP _____

Printed name: _____

Date: _____

Staff Use Only

Fitness Program _____

Living Well _____