A Shape For Life
medical weight loss
Walter G. Griffith, Jr., MD

5565 MLK St. N, St. Petersburg, Fl 33703
Phone#727-578-2322 // Fax#727-577-0983

NEW PATIENT QUESTIONNAIRE

General Information

Name:_____ Date:_____

Address:_____City:_____Zip:_____

Tel#'s: (Home)_____ (Cell)_____ (Work)_____

Date of Birth:_____ Age:_____ Religion:_____

Job Title/Employer:_____ #yrs _____

SS#_____ #Children & Ages:_____

Family Doctor:_____ Drug Allergies:_____

How did you hear about A Shape for Life?? ☐ a friend ☐ a doctor ☐ online ☐other_____

Marital Status

☐single ☐married (#times_____) ☐divorced ☐separated ☐engaged ☐cohabitating ☐widowed

Significant Other:

#yrs together_____ First Name:_____ Age:_____ Job:_____

Weight Data & History

Height _____ft _____in Current Weight_____ Target Weight _____ Current Pant Size _____ Target Pant Size_____

When did your weight problem begin? ☐ childhood ☐teenage years ☐adulthood

Do you exercise? ☐usually daily ☐a few times/week ☐about once/week ☐not much at all

If so, please describe your exercise routine: _____

_____

What factors do you feel most contribute to your current weight problem:

1)_____

2)_____

3)_____

Typical Daily Meal & Snack Times and Food Choices

Time of Day	Please use a checkmark to indicate your frequency of eating a meal or snack at the time of day listed in the far left column					Please list your typical food choices for the times of day shown in the far left column
	Every day	Most days	½ the days	Not often	Almost never	
Breakfast						_____
Mid-Morning						_____
Lunch						_____
Afternoon						_____
Dinner						_____
Evening						_____

Which part of the day do you feel the hungriest?

☐morning ☐mid-morning ☐lunchtime ☐afternoon ☐dinner time ☐after dinner/late evening

Which part of the day do you typically eat the most food?

☐morning ☐mid-morning ☐lunchtime ☐afternoon ☐dinner time ☐after dinner/late evening

How many times in a typical week do you eat out at restaurants? _____/week

How many times of those restaurant meals include drinking alcohol? _____/week

What are the most stressful parts of your life?

1) _____

2) _____

3) _____

Typical Weekly Food Choices

Name of Food	Estimated Frequency of Consumption (servings/week)
Fruit Juices – eg, orange, apple	
Regular Soda – sweetened (not diet)	
Diet Drinks – drinks with artificial sweeteners	
Alcoholic Drinks – beer/wine/liquor	
Candy	
Chocolate	
Cake/Pastries/Desserts	
Breads	
Breakfast Cereals	
Pasta/Noodles	
Rice	
Potatoes	
Chips	
Pretzels	
Crackers	
Beef	
Chicken	
Turkey	
Pork/Bacon/Ham	
Lamb	
Seafood	
Eggs	
Cheese	
Fruits	
Vegetables	

Previous Weight Loss Attempts

Name of Approach	Not so helpful	Fairly helpful	Describe your success using this approach
Portion-Control Dieting			
Weight Watchers			
Atkins			
Jenny Craig			
NutriSystem			
Exercise – Home Based			
Exercise – Gym Based			
Over the counter pills			
Doctor Rx'd Medication			
Other: _____			

Past Medical History

Hospitalizations/Surgeries		
Year	Hospital/Location	Nature of Illness

Current Medication Information

Medication	Mg/day	Reason on Medication

Are you NOW having any of the following problems?		Have you had any of these medical problems?	
☐ Loss of consciousness	☐ Eye pain, double vision	☐ Hypertension	☐ Diabetes
☐ Hearing loss, ringing	☐ Dizziness	☐ Stroke	☐ Heart Attacks
☐ Lightheaded standing	☐ Shortness of breath	☐ Thyroid Problems	☐ Chronic Headaches
☐ Chest pain	☐ Ankle swelling	☐ Arthritis	☐ Ulcers
☐ Bloody or pink urine	☐ Severe abdominal pain	☐ Kidney Stones	☐ Seizures
☐ Frequent heartburn	☐ Tar-colored stools	☐ Cancer type _____	☐ Other _____

Additions/Comments_____

_____

Patient Signature _____ Date_____