--- Clinical Nutrition Center ---

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WEIGHT CONTROL QUESTIONNAIRE and MEDICAL HISTORY

This questionnaire is to assist you in giving us information concerning your past weight history, medical history, previous diet attempts, dietary habits, and need for weight control. Please complete ALL questions accurately and as carefully as possible. If a question does not pertain to you, mark it NA (not-applicable). Please fill this questionnaire out when you have plenty of time to do so. DO NOT HURRY THROUGH IT. This will take approximately 20 minutes to complete.

I. GENERAL INFORMATION

Today's Date:	
First Name:	
Last Name:	
Home Phone: (###) ###-####	
Work Phone:	
Cell Phone:	
Street Address:	
Apartment Number	
City:	
State:	
Zip Code:	
e-mail	
Emergency Contact:	
Emergency Contact Phone:	
Sex (Female or Male):	☐ Female ☐ Male
Date of Birth (month/day/year):	
How did you hear about us?	
Marital Status:	
Social Security Number:	
Occupation:	
Employer:	
Title / Degree:	

II. HEALTH INFORMATION:

Primary Care Physician (PCP):

First Name:	
Last Name:	
PCP phone number:	
PCP Street Address:	
PCP Suite / Office Number:	
PCP City:	