Food & Nutrition Services
Outpatient History Form

East Jefferson General Hospital
LCMC Health

Please answer each of the questions below. The information you share will help the Registered Dietitian have a better understanding of your needs.

Name: _____ Phone: _____

E-mail Address: _____

Reason for Visit: _____

What do you expect to learn in this visit? _____
_____
_____

1. Are you concerned about your weight?
   - ❑ No (Skip to question 4)
   - ❑ Yes, I want to stop gaining weight (Skip to question 3)
   - ❑ Yes, I want to lose weight
2. What is your goal weight? _____ lbs
3. What was your lowest adult weight? _____ Age at this weight? _____

   What was your highest adult weight? _____ Age at this weight? _____
4. Do you take any vitamin, mineral or herbal dietary supplements (like protein powder)?
   - ❑ Yes List _____
   - ❑ No
5. Do you smoke cigarettes?
   - ❑ Yes – How many per day? _____
   - ❑ No
6. Are you on a diet or taking medication to lose weight or maintain your weight?
   - ❑ No
   - ❑ Yes, Please list diet or medications: _____
     _____
     _____
7. Have you tried to lose weight in the past?
   - ❑ No (Skip to question 10)
   - ❑ Yes, I lost _____ lbs over this period of time: _____

     How much of this weight, if any, did you gain back? _____ lbs
     What worked best for you and why? _____
     _____
     _____
     _____
8. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?
   - ❑ Yes
   - ❑ No

Outpatient History Form Continued

9. Do you ever feel that your eating is out of control?
   - ❑ No
   - ❑ Yes – When: _____

10. Do you participate in regular physical activity?
   - ❑ No
   - ❑ Yes – Describe:

LIST YOUR ACTIVITIES	TIMES PER WEEK	DURATION OF ACTIVITY
1.		
2.		
3.		
4.		

11. On a scale of 0 to 10, circle the number that shows how **important** it is for you to make lifestyle changes? (**Lifestyle changes** are changes to improve your health, such as changing your diet and increasing your physical activity.)

0 1 2 3 4 5 6 7 8 9 10
Not very important Somewhat important Very important

12. What things might make it hard for you to make lifestyle changes?

_____
_____

13. On a scale of 0 to 10, circle the number that shows your current level of stress.

0 1 2 3 4 5 6 7 8 9 10
Very Relaxed Managing OK Very Stressed

14. Check any that apply:
   - ❑ I live alone.
   - ❑ My family eats most meals together.
   - ❑ Family meals are served at regular times on most days.
   - ❑ I have a supportive family/friend to help me with my weight loss efforts.
   - ❑ Another member of my family/my friend is on special diet or is trying to lose weight. Describe: _____
   - ❑ I eat (check all that apply):
     - ❑ Heat and serve meals how often _____
     - ❑ Home-cooked meals how often _____
     - ❑ Fast foods how often _____
     - ❑ Restaurant or grocery take out how often _____

15. What prescription medications are you currently taking and for what reason? List.

_____
_____
_____

Please check to be sure you have answered all questions. Thank you very much!