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DUKE DFC MEDICAL QUESTIONNAIRE

PERSONAL INFORMATION

NAME:		DATE:	
DATE OF BIRTH: / /	AGE:	GENDER:	OCCUPATION:
PARTNER/MARITAL STATUS: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partner <input type="checkbox"/> divorced <input type="checkbox"/> widowed			

GENERAL HEALTH

How would you describe your health?

Excellent Good Fair Poor

What is/are your major health concern(s)?

What is/are your personal goals as you enter our program?

List one or more changes in the way you feel or your ability to do things that would be a measure of the success of your effort at the Diet and Fitness Center.

WEIGHT HISTORY

To the best of your ability, please answer the following questions about your personal weight history.

At approximately what age did you first consider yourself overweight? _____

What has been your heaviest weight? _____ Lbs. At What Age? _____

Approximately how many times have you lost more than 10 lbs? _____

What was your greatest weight loss in one attempt? _____ Lbs. When? _____
How did you accomplish this? _____

How long were you able to maintain that weight? _____

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What do you consider to be the major obstacles to your efforts to control your weight and to maintain a physically active lifestyle? _____

WEIGHT HISTORY

(continued...)

To the best of your ability, please answer the following questions about your personal weight history.

Approximate Age (Years)	Weight	Approximate Age (Years)	Weight
10	_____	40	_____
21	_____	50	_____
30	_____	60	_____
		70	_____
		80	_____

Check all the methods you have used to try to lose weight.

- | | |
|--|---|
| <ul style="list-style-type: none"> ___ Dietician's Advise ___ Liquid Diets ___ Fasting ___ Laxatives ___ Self-induced vomiting ___ Fitness program ___ Weight Watchers ___ NutriSystem ___ Pritikin ___ Overeaters Anonymous ___ Other weight loss programs | <ul style="list-style-type: none"> <input type="checkbox"/> Weight loss medication <li style="padding-left: 20px;">If Yes, please indicate medication below: <li style="padding-left: 20px;">Redux Yes No <li style="padding-left: 20px;">Phen-Fen Yes No <li style="padding-left: 20px;">Meridia Yes No <li style="padding-left: 20px;">Xenical Yes No <li style="padding-left: 20px;">Herbal Product(s) Yes No <li style="padding-left: 20px;">Other: _____ <input type="checkbox"/> Self-help books <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____ |
|--|---|

PHYSICAL ACTIVITY

Do you engage in moderately intense activity at least 30 minutes a day, 4 days of the week? Yes No

List the major ways in which you are physically active either as part of your daily life – climbing stairs, walking at work, house-associated chores (cleaning, making beds, gardening) or through formal exercise.

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In your adult life, have you been more active than you are currently? Yes No

If yes, what caused you to cut back on this activity?

.....

.....

.....

DUKE DFC MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

(continued...)

	YES	NO	UNSURE	
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Clinician Comments</i>
If YES, when was it diagnosed?	_____			
If YES, have you been treated with any medications you have had to discontinue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES , please list medications you have stopped and the reasons why:				

	YES	NO	UNSURE	
ABNORMAL LIPIDS <i>(cholesterol or triglycerides)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Clinician Comments</i>
If YES, when was it diagnosed?	_____			
If YES , have you been treated with any medications you have had to discontinue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES , please list medications you have stopped and reasons why:				

	YES	NO	UNSURE	
SLEEP DISORDERS				<i>Clinician Comments</i>
Have you ever had a formal sleep study?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES, what did the test show?				

Do you use any treatment such as CPAP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES, please list any treatments:				

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LIFESTYLE HABITS	Current Use		Past Use	
	No	Yes	No	Yes
Cigarettes				
Cigars				
Smokeless Tobacco/Snuff				
If you smoke, how much do you smoke per day? _____		For how many years? _____		
If you quit smoking, when did you quit? _____				
Alcohol				
If current use:	No	Yes		
Have you ever felt you should cut back on your drinking?				
Have people annoyed you by criticizing your drinking?				
Have you ever felt bad or guilty about your drinking?				
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?				
If you drink alcohol, approx. how much and what do you drink in an average week? _____				
Drug use:				
Do you wear seatbelts?				
<i>Clinician Comments</i>				

Do you have any drug or medication allergies?

ρNo ρYes

If yes, please list them:

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FAMILY HISTORY

	If living, age and health:	If deceased, age and cause:
Father		
Mother		
Brothers		
Sisters		
Children		

Did anyone in your immediate family (parents, brothers, or sisters) have heart disease or stroke when they were <55 years of age/men, <65 years of age/women? No Yes

Clinician Comments:

PREVENTIVE HEALTH MEASURES

Approximately when was your last test for:	Never	Unsure	Approximate Date	Results
Blood Sugar Test				
Cholesterol/Triglycerides				
Exercise Stress Test				
Rectal Exam				
Prostate Test (PSA) (men only)				
Check of your stool for blood				
Mammogram (women)				
Breast Exam (women)				
Pap smear (women)				
Bone density test				
Flexible sigmoidoscopy				
Colonoscopy				
Tetanus shot				
Pneumonia shot				
Flu shot				

REVIEW OF SYSTEMS

PAIN

List major activities, which are limited by pain. Indicate the degree of pain you have on a scale from 0-10 with 10 being the worst pain imaginable.

Activity	Pain Scale	Location of Pain

GENERAL

Please check YES or NO as appropriate regarding the following current or recent (within the past few months) symptoms. If you are not sure, leave blank.

Symptom	Yes	No
Fatigue daily, or most days		
Lack of appetite		
Excess appetite		
Weight loss		
Chills		
Fever		
Night sweats		
Difficulty getting to sleep, most days		
Difficulty staying asleep, most days		

Clinician Comments:

EYES, EARS, NOSE, THROAT

Symptom	Yes	No
Visual symptoms		
Hearing problems		
Nosebleeds		
Sinus trouble		
Hay fever/allergies		
Sore throat		
Hoarseness		
Bleeding gums		

Clinician Comments:

ENDOCRINE

Symptom	Yes	No
Goiter (enlarged thyroid glands)		
Heat intolerance (sensitivity)		
Cold intolerance (sensitivity)		
Tremulousness of the hands		
Increased thirst		
Excessive urination		
Thyroid gland malfunction		
Other "gland" or hormone problems		

WOMEN ONLY -

Regular menstrual periods		
Abnormal menstrual periods		
Excessive facial hair		

Clinician Comments:

SKIN

Symptom	Yes	No
Rash		
Change in hair (hair loss/excessive growth)		
Skin breakdown or ulcers		
Change in mole or other skin lesion		
Other:		

*Clinician Comments:***RESPIRATORY**

Symptom	Yes	No
Frequent coughing		
Coughing up blood		
Pain in chest with cough, sneeze or movement		
Wheezing		
Asthma		
Frequent, loud snoring		
Spells of not breathing while sleeping		
Excessive daytime sleepiness (fall asleep in meetings, watching TV, and driving)		

*Clinician Comments:***CARDIOVASCULAR**

Symptom	Yes	No
Chest pain, tightness or squeezing		
Shortness of breath at rest		
Shortness of breath with mild or moderate activity		

Heart racing (other than with vigorous activity)		
Irregular heart beat		
Heart murmur		
Faintness, passing out		
Episodes of waking from sleep, feeling like smothering from lack of air.		
Requiring propping up on several pillows to breathe at night		
Swelling of the legs		
Leg muscle pain (not joint pain) associated with exertion		

*Clinician Comments:***BREASTS**

Symptom	Yes	No
Lumps		
Pain		
Discharge		

Clinician Comments:

GASTROINTESTINAL

Symptom	Yes	No
Diarrhea		
Constipation		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Bright red blood in stools		
Black stools		
Change in bowel habits		
Food intolerance		
Need for antacids		
Hemorrhoids		

Clinician Comments:

URINARY

Symptom	Yes	No
Pain or burning during urination		
Frequent urination, day or night		
Extreme urge to urinate		
Difficulty starting urinary stream		
Difficulty stopping urinary stream		
Involuntary loss of urine		
Kidney stones		

Clinician Comments:

GENITAL-REPRODUCTIVE (Male)

Symptom	Yes	No
Discharge from penis?		
Testicular pain?		
Lumps in testicles or scrotum?		
Change in testicular size?		
Decreased sexual desire?		
Decreased ability to achieve erection?		
Satisfied with sex life?		
Problems with ejaculation?		
Any sexually transmitted or venereal disease?		

If YES, what type and when?

Are you taking any male hormones?		
Have you used Viagra, Cialis, or Levitra?		
Are you considering taking Viagra, Cialis, or Levitra?		

Clinician Comments:

GENITAL-REPRODUCTIVE (Female)

Symptom	Yes	No
Age of onset of menstrual periods		
Age at which periods stopped		
If still menstruating:		
How far apart are your periods?		
How many days do periods last?		
If flow heavy, scanty or normal? (<i>circle one</i>)		
Date of your last normal period?		
Date of last period before that?		
Do you ever bleed between periods?		
Do you ever have to go to bed because of cramps?		
Do you have heavy vaginal discharge?		
Have you had any vaginal bleeding since menopause?		
Are you bothered by hot flashes?		
FOR ALL WOMEN:		
Have you had any sexually transmitted or venereal disease?		

If YES, what type?

Do you have pain with intercourse?		
Do you have decreased sexual desire?		
Are you taking any female hormones?		
Satisfied with sex life?		

Clinician Comments:

OBSTETRICAL

Symptom	Yes	No	If Yes, how many?
Pregnancies			
Full term deliveries			
Miscarriages			

Stillbirths			
Abortions			
Complications:			
High blood pressure.			
Toxemia?			
Any children over 9 lb at birth.			
Gestational diabetes?			

Clinician Comments:

MUSCULOSKELETAL

Symptom	Yes	No
Painful joints (which joints?)		
Swelling of joints		
Stiffness of joints		
Deformities of the joints or the extremities		
Back pain		
Muscle pain		
Gout		
Joint or limb giving way		
Dislocations		
Do you have any concerns about injuring yourself while exercising?		
Have you ever had to limit your physical activity because of muscle, joint or bone problems?		

Clinician Comments:

NEUROLOGIC

Symptom	Yes	No
Headaches		
Memory difficulty		
Difficulty thinking or problem solving		
Difficulty with speech		
Difficulty with or loss of strength		
Loss of sensation		
Loss of balance		
Loss of coordination		
Impaired gait		
Seizures		
Paralysis/weakness of a limb(s)		
Double vision		
Dizziness		
Blackouts		
'TIA' (mini stroke)		
Stroke		
Tremor		

Clinician Comments:

Clinician Comments:

CANCER

Symptom	Yes	No
Any history of past cancers?		
If YES, please explain. What kind, when, and how treated?		

Clinician Comments:

FALLS HISTORY

Are you worried you might fall?	Yes	No
Have you ever fallen?	Yes	No

How many times in past year?

How many times in past six months?

How many times in past two weeks?

Have you had any injuries from falls?

If yes, please tell when and where the fall(s) occurred and what injury occurred

Do you have any persisting injury from any fall?

PSYCHIATRIC

Symptom	Yes	No
Depression		
Anxiety		
Past history of depression		
Past history of psychiatric illness		
Any history of attempted suicide?		

Other psychiatric illness?

- | | |
|---|--|
| ρ <i>Panic Disorder</i> | ρ <i>Schizophrenia</i> |
| ρ <i>Anxiety Attacks</i> | ρ <i>Bipolar</i> |
| ρ <i>Attention Deficit Disorder (ADD)</i> | ρ <i>Obsessive Compulsive Disorder (OCD)</i> |