Horizon Health Medical Clinic

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HEALTH INFORMATION QUESTIONNAIRE

Dear patient,

In order to provide you with the comprehensive and individualized care in our clinic, we would like to learn more about you. The following questions ask about your weight, nutrition, activity, and medical history, along with social factors which could contribute to your health. Please fill out this questionnaire to the best of your knowledge.

The information you provide us with, will be stored securely and kept confidential according to the Privacy Act.

Thank you for your time and we are looking forward to working with you towards reaching your goals!

WEIGHT HISTORY

When did you begin to be concerned about your weight?

☐ childhood ☐ adolescence ☐ 20s ☐ 30s ☐ 40s ☐ 50s

What was your highest weight (excluding pregnancy)? _____ When? _____

Can you identify any specific event which may have triggered weight gain?

_____

What is your realistic goal weight? _____

Comments _____

_____

NUTRITION HISTORY

Have you seen a Dietitian before? ☐ No ☐ Yes – reason? _____

Have you gone to any nutrition group classes? ☐ No ☐ Yes

Do you use a food journal or tracker? ☐ No ☐ I did in the past ☐ Yes

Was the following often true, sometimes true, or never true in the past 12 months?

	Never true	Sometimes true	Often true
You / you and other household members worried that food would run out before you got money to buy more	☐	☐	☐
You / you and other household members couldn't afford to eat balanced meals	☐	☐	☐
You / you or other adults in your household] ever cut the size of your meals or skip meals because there wasn't enough money for food?	☐	☐	☐

Who does this at your house? (e.g. me, my spouse, parents, friends)

Shop for groceries	
Prepare meals/ cooking	
Make decisions about what you eat	

HEALTH INFORMATION QUESTIONNAIRE

When do you eat in a typical day? _____Please check all that apply:

☐ Breakfast ☐ Lunch ☐ Supper ☐ Bedtime ☐ Middle of the night

☐ Morning snack ☐ Afternoon snack ☐ Evening snack

How often do you eat foods away from home? (e.g., food from a restaurant, go through a drive-thru, order take-out, or get food delivered):

☐ Breakfast ___ / week ☐ Lunch ___ / week ☐ Supper ___ / week ☐ Snacks ___ / week

Do you have diet restrictions or limitations for any reason (health, cultural, religious, or other)? ☐ No ☐ Yes, please describe _____

_____

_____

What factors are a concern for you that impact your weight and health?

Factors	Yes	No	Factors	Yes	No
Eating too often /grazing	☐	☐	Liquid calories (pop, juice, coffee)	☐	☐
Unhealthy food choices	☐	☐	Hunger	☐	☐
Night time eating	☐	☐	Eating when feeling overwhelmed, anxious	☐	☐
Craving certain foods	☐	☐	Problems chewing or swallowing	☐	☐
Large portions at meals	☐	☐	Eating too much when socializing or celebrating	☐	☐
Eating out often	☐	☐	I'm not as active as I want to be	☐	☐
Eating when bored	☐	☐	No time to cook / make meals	☐	☐
Eating when stressed	☐	☐	No energy to do housework or shopping	☐	☐
Eating when sad	☐	☐	Stress from work or family	☐	☐
Skipping meals	☐	☐	I can't stand long enough to cook	☐	☐
Shift work	☐	☐	Hard to follow a program or plan	☐	☐
Not feeling full	☐	☐	Frustrated with lack of results	☐	☐
No time to be active	☐	☐	Other _____	☐	☐

What is your main concern? _____

_____

_____

How often does this occur? _____

_____

HEALTH INFORMATION QUESTIONNAIRE

Have you tried any of these diets, products or programs for weight loss? (*check all that apply*)

Diets		Products	Programs
☐ Detox diets	☐ Low fat	☐ Herbal supplement	☐ Dr. Bernstein Diet
☐ Fasting (e.g. intermittent fasting)	☐ High protein	☐ Packaged meals	☐ Nutrisystem®
☐ Glycemic Index (GI)	☐ Juicing	☐ Powders	☐ Jenny Craig®
☐ Gluten-free (not celiac)	☐ Keto	☐ Shakes or drinks	☐ Optifast 900®
☐ Low calorie (below 1200/day	☐ Mediterranean		☐ Weight Watchers®
☐ Low carbohydrate (e.g. Atkins)	☐ Vegetarian/ Vegan		☐ Online or App
If other, please provide details:			

Are you currently following any specific diet? ☐ No ☐ Yes – which one? _____

PHYSICAL ACTIVITY AND FUNCTION

Do you use any mobility aids? ☐ No ☐ Yes, please specify:

☐ Cane, walking stick ☐ Walker ☐Scooter ☐ Wheelchair

Do you need help around the house to shower, get dressed or housework?

☐ No ☐ Yes, please explain: _____

Do you do any physical activity? ☐ No, only my daily routines ☐ Yes – please, list below

Type of Activity (e.g. walking, swimming)	**Time** (minutes)	**How often?** (days per week)	**Intensity** (low, medium, high)

Do you use a pedometer? ☐ No ☐ Yes _____ steps per day

TREATMENT OPTIONS

Are you interested in medications to assist with weight loss? ☐ Yes ☐ No ☐ Undecided

Have you previously been prescribed medications for weight loss?

☐ orlistat (Xenical™) ☐ liraglutide (Victoza™, Saxenda™) ☐ semiglutide (Ozempic™)

☐ bupropion (Wellbutrin™) ☐ bupropion/naltrexone (Contrave™) ☐ other: _____

Are you interested in bariatric (weight loss) surgery? ☐ Yes ☐ No ☐ Undecided

Please comment: _____

HEALTH INFORMATION QUESTIONNAIRE

SOCIAL HISTORY

Marital status:

☐ single
☐ married
☐ widowed
☐ divorced
☐ separated
☐ common-law

Education:

☐ primary (gr 1-8)
☐ secondary (gr 9-13)
☐ college / university

Occupation:

_____

Employment:

☐ full time
☐ part time
☐ retired
☐ unemployed
☐ disability
☐ shift work

Drug Coverage / Plan: ☐ Yes ☐ No Name of insurer _____

HABITS

Smoking:

☐ non-smoker
☐ ex-smoker
☐ currently smoking
☐ other tobacco use
☐ vaping
☐ cannabis

Alcohol:

☐ never
☐ socially
Servings per week_____
History of alcohol addiction?
☐ No ☐ Yes
Quit: ☐ No ☐ Yes
When? _____

Recreational/Street Drugs:

☐ never
☐ prior use
Year quit_____
Substance_____
☐ current use
Substance _____

MEDICAL PROFILE

Cardiovascular

☐ high blood pressure ☐ atrial fibrillation ☐ heart failure ☐ coronary artery disease
☐ history of heart attack when? _____ ☐ other: _____

Did you have any heart tests done? *(check all that apply, include month/year beside each)*

☐ echocardiogram _____ ☐ stress test _____ ☐ MIBI _____
☐ angiogram/angioplasty _____ ☐ ECG _____

Respiratory

☐ sleep apnea: ☐ No ☐ Yes ☐ I do not know If yes, are you on: ☐ CPAP ☐ BiPAP ☐ oral appliance
☐ asthma ☐ COPD (emphysema/chronic bronchitis)
☐ pulmonary embolus (blood clot) ☐ other_____

Gastrointestinal

☐ heartburn / GERD ☐ fatty liver disease ☐ gallstones ☐ history of pancreatitis

HEALTH INFORMATION QUESTIONNAIRE

☐ celiac ☐ Crohns / ulcerative colitis ☐ IBS ☐ hepatitis
☐ cirrhosis ☐ other_____ ☐ hernia – type_____

Did you have any gastrointestinal tests done? *(check all that apply, include month/year beside each)*

☐ abdominal Ultrasound_____ ☐ abdominal CT_____
☐ barium Swallow _____ ☐ Urea Breath Test _____
☐ gastroscopy_____ ☐ colonoscopy _____

Neurological

☐ history of seizures stroke ☐ transient ischemic attack (mini-stroke)
☐ migraines ☐ other _____

Endocrine

☐ diabetes: ☐ type 2 ☐ type 1
☐ diabetes complications: ☐ eye issues ☐ nerve pain ☐ protein in urine
☐ pre-diabetes ☐ gestational diabetes ☐ high cholesterol ☐ polycystic ovary disease
☐ hyperthyroidism ☐ hypothyroidism ☐ history of thyroid cancer ☐ other_____

Musculoskeletal

☐ osteoarthritis ☐ chronic pain ☐ fibromyalgia ☐ mobility issues

Genitourinary

☐ kidney stones ☐ stress incontinence ☐ benign prostatic hyperplasia

Autoimmune Disorders

☐ multiple sclerosis ☐ lupus ☐ rheumatoid arthritis ☐ myasthenia gravis

Cancer History

☐ breast ☐ colon ☐ uterine ☐ thyroid ☐ prostate ☐ other: _____

Mental Health

☐ depression ☐ anxiety ☐ ADHD ☐ binge eating disorder ☐ bipolar disorder
☐ schizophrenia ☐ history of self-harm or thoughts of suicide ☐ other eating disorder (bulimia, anorexia)
☐ history of abuse: ☐ mental ☐ physical ☐ sexual

Admission to hospital for PSYCHIATRIC issues: ☐ No ☐ Yes, details: _____

HEALTH INFORMATION QUESTIONNAIRE

WOMEN'S HEALTH (for females only)

Birth Control

☐ birth control pill ☐ condoms
☐ IUD ☐ vasectomy
☐ ring/patch ☐ tubal ligation
☐ none

Pregnancy History

Number of pregnancies: _____
Number of births: _____

Menstrual Cycle

☐ regular
☐ irregular
☐ heavy
☐ menopause

Planning future pregnancies: ☐ Yes ☐ No

FAMILY HISTORY

Please indicate if your relative(s) have had/currently have the following by placing an X in appropriate column

Family Member	Overweight Obesity	Heart disease	Diabetes	High blood pressure	High cholesterol	Stroke	Seizures	Cancer
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐
Biological Children	☐	☐	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS AND SURGERIES

List any hospitalizations, surgeries, or procedures you have had performed.

Surgery or procedure	Date

SPECIALISTS – List any other doctors involved in your care

Name	Specialty

MEDICATIONS – Please complete the attached form

ALLERGIES – **Are you allergic to any medications?** ☐ No ☐ Yes, please list:_____

Please list any food allergies, sensitivities or intolerances: _____

OTHER INFORMATION _____

Medication List

Please include prescribed and over-the-counter medications/supplements

Name:	**Date:**			
Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total ____ =	**____**	**+ ____**	**+ ____**	**+ ____**
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ____	Somewhat difficult ____	Very difficult ____	Extremely difficult ____

	Not at all	Several days	More than half the days	Nearly every day
Over the last 2 weeks, how often have you been bothered by the following problems?				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score*¶ _____ =	Add Columns	_____ +	_____ +	_____
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months…	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

STOP-Bang questionnaire

☐ Yes	☐ No	**Snoring?** Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
☐ Yes	☐ No	**Tired?** Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)?
☐ Yes	☐ No	**Observed?** Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep?
☐ Yes	☐ No	**Pressure?** Do you have or are you being treated for **high blood pressure**?
☐ Yes	☐ No	**Body mass index more than 35 kg/m^2?**
☐ Yes	☐ No	**Age older than 50 years old?**
☐ Yes	☐ No	**Neck size large (measured around Adam's apple)?** Is your shirt collar 16 inches or larger?
☐ Yes	☐ No	**Gender (biologic sex) = Male?**

Scoring criteria:
Low risk of OSA: Yes to 0 to 2 questions
Intermediate risk of OSA: Yes to 3 to 4 questions
High risk of OSA: Yes to 5 to 8 questions