

The Center for Weight Control and Diabetes Management

4000 Highland, #110, Waterford, Michigan 48328

Patient Diet History Questionnaire

Patient name: _____

Date: _____

Please complete the following statements by circling the correct word(s) in columns A or B.

	A	B	
1. I	have	have not	been overweight since childhood.
2. I	have never	have	weighed much more than I do now.
3. It	has	has not	been a problem for me to lose weight.
4. I	am not	am	very motivated to lose weight right now.
5. There	are	are not	many stresses in my life.
6. I	do	do not	eat when I am not hungry.
7. I	am	am not	hungry most of the time.
8. I	do	do not	miss meals often.
9. I	do	do not	eat when I am bored.
10. I	do	do not	eat when I am stressed out.
11. I	do	do not	eat high-fat snacks between meals.
12. I	do	do not	eat high-fat snacks in the evening.
13. I	do	do not	eat large amounts of food at one time.
14. I	do	do not	feel that my eating is out of control at times.
15. I	have	have not	purged, vomited, or used laxatives.
16. I	do	do not	drink alcohol every day.
17. I	do	do not	smoke.
18. I	do not	do	exercise regularly.
19. I	do	do not	feel depressed, sad, or blue.
20. I	have	have not	had little interest in doing things.
21. I	do	do not	eat fried foods regularly.
22. I	do	do not	use butter or margarine regularly.
23. I	do	do not	eat cheese or pizza regularly.
24. I	do	do not	eat cookies, cakes, or candy regularly.
25. I	do	do not	eat red meat, or cold cuts regularly.
26. I	do	do not	eat nuts, chips, or dip regularly.
27. I	do not	do	eat fruits and vegetables often.
28. I	do not	do	like being physically active.
29. I	do not	do	think I can exercise right now.

Complete this statement: I want to lose _____ pounds, because _____

My breakfast usually is _____

My lunch usually is _____

My dinner usually is _____

My favorite snack is _____