AT THE FOREFRONT

UChicago Medicine

Welcome to Chicago Weight

Dear Patient,

Welcome to Chicago Weight, the weight-management program at University of Chicago Medicine. You are scheduled for evaluation with a doctor and a nutritionist. At your initial evaluation you may be referred to meet a health psychologist in our program. This packet includes health screening questionnaires. Please complete the enclosed questionnaires at home and bring them with you on the day of your appointment. Do take time and put real thought into your answers because this information will be important to your initial assessment and the development of your individualized treatment plan.

Please arrive 15 minutes before your appointment at Chicago Weight. If you need to cancel your appointment, please give our office advanced notice of at least 3 business days by calling 773-702-6138.

We look forward to meeting you soon.

Sincerely,

The University of Chicago Medicine Weight Management Team

Silvana Pannain, MD

Director, Chicago Weight

The University of Chicago Medicine
150 E. Huron St.

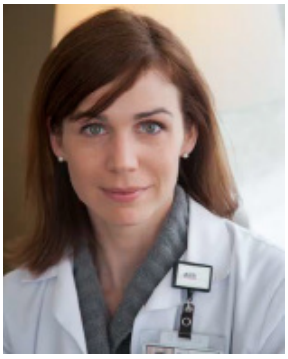
The Metabolic Team at Chicago Weight

Taylor Durkin, RD, LDN, is a registered dietitian with Chicago Weight and the Kovler Diabetes Center at University of Chicago Medicine. Durkin educates patients on the importance of integrating a well-balanced eating pattern to assist in weight management and to achieve better glycemic control. She also supports them in developing and attaining their nutrition goals through individualized dietary recommendations for improvement in overall health and diabetes outcomes.

Taylor Durkin, RD, LDN

Silvana Pannain, MD, Director of Chicago Weight, is a board-certified endocrinologist and a bariatric physician, with extensive experience in managing patients with excess weight and related comorbidities. Qualified as a cardiologist in Italy, she has since trained and worked as an endocrinologist at the UChicago Medicine since 2002. During this time, she has conducted clinical research into the effects of poor sleep and obstructive sleep apnea on weight gain, diabetes and cardiovascular risk factors.

Silvana Pannain, MD



Cathleen Mulcahy, MSN, APN, FNP, is a board-certified family nurse practitioner, specifically trained in the management of chronic diseases. Ms. Mulcahy has worked closely with Dr. Pannain in co-managing patients with diabetes, hypertension and thyroid diseases since 2009 and has worked for Chicago Weight since 2012. As a nurse practitioner, she coaches patients on the development of lifestyle and behavior changes that promote healthy, balanced eating, and monitors patients' response to weight loss drugs and comorbidity treatments.

Cathleen Mulcahy, MSN, APN, FNP

Health and Wellness at Chicago Weight

Andrea Busby, PhD, is a licensed clinical psychologist who specializes in health psychology. Dr. Busby uses cognitive-behavioral treatment to assist patients with implementing dietary and activity changes to facilitate weight loss. Dr. Busby also provides treatment for binge eating, emotional eating, depression, and anxiety which are often barriers to successful and lasting weight loss.

Andrea Busby, PhD

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UChicago Medicine

Health History Questionnaire

Background Information

Marital status: _____

Number and ages of children (if applicable): _____

Work hours: _____ (example 9 am to 5 pm)

Occupation:_____

Highest level of education: _____

Have you ever been diagnosed with a learning problem (i.e., learning disability, dyslexia, etc.)? _____

Please list the people in your household and their relationships to you: _____

_____

_____

Where were you born (city, state, country)? _____

Where were you raised (city, state, country)? _____

Who raised you? _____

How many siblings do you have? _____

How do you rate your health?

_____ Good _____ Excellent _____ Fair _____ Poor

Have you ever been diagnosed with any of the following? (please circle, if yes):

Respiratory

Shortness of Breath
Coughing
Asthma or Wheezing
Chronic Bronchitis or COPD
Emphysema
Snoring
Daytime Sleepiness
Disturbed Sleep
Sleep Apnea
History of Pneumonia

Cardiovascular

High Blood Pressure
Heart Disease/Heart Attack
Congestive Heart Failure
Irregular Heart Beat or Palpitations
Blood Clots or Clotting Disorders
Chest Pain or Discomfort
Ankle or Feet Swelling
Varicose Veins
Heart Murmur

Genitourinary

Difficulty Urinating
Urinary Incontinence (Leaking Urine)
Enlarged Prostate
History of Kidney Stones
Inability to Empty Badder Fully
Recurrent Urinary Tract Infections (UTI)
Sexual Problems
Infertility

Gastrointestinal

Gastroparesis
Chronic Constipation
Heartburn
Irritable Bowel Disease
Inflammatory Bowel Disease
History of Weight Loss Surgery

Musculoskeletal

Aching Muscles or Joints
Gout
Lower Back Pain/Disc Problems
Arthritis

Endocrine

Diabetes Mellitus
High Triglycerides
High Cholesterol
Polycystic Ovarian Syndrome (PCOS)
Thyroid Disease

Skin and Hair

Skin Sores or Infections (Boils, Ulcers, Skin Fold Irritations)
Excessive Facial/Body Hair (women only)
Bruises Easily
Chronic Rashes or Dermatitis or Eczema

Other

History of Glaucoma Low Energy Level Headaches
Migraines

Cancer (list type): _____

Other serious medical conditions (list types): _____

_____

_____

List the types of surgeries you have had: _____

_____

_____

Mental Health

Have you ever been evaluated for a mental health problem? **Y** **N**

If yes, have you ever been given a mental health diagnosis? **Y** **N** If yes, please list the diagnosis/diagnoses and approximate year they were given (for example, "depression in 1998, anxiety in 2001"): _____

_____

Have you been diagnosed with an eating disorder? **Y** **N** If yes, please specify the disorder_____

Have you experienced child abuse, rape, or molestation? **Y** **N** **N/A** (I elect not to answer)

Are you currently in mental health treatment? **Y** **N**

If yes, please list the type(s) of treatment (i.e., therapy, medication, hypnosis, ECT, etc.):

_____

Have you participated in mental health treatment in the past? **Y** **N**

If yes, please list the type(s) of treatment (i.e., therapy, medication, hypnosis, ECT, etc.) and approximate time frame (for example, "Zoloft for depression 1998-2000, therapy for anxiety 2001-2002):

_____

On a scale from 1 (low stress), to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____

_____

Patient Health Questionnaire (PHQ-9)

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
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself.... Or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. 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				
9. Thoughts that you would be better off dead, or of hurting yourself				

10. 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 _____

Family History

Do you have a family history of any of the following? (circle all that apply)

High Blood Pressure	High Blood Cholesterol	Diabetes
Obesity	Heart Disease	Cancer, if yes please specify
Mental Health Problems	Alcohol or Substance Abuse	Thyroid Disease

Other (list): _____

Social History

Do you use any tobacco products? **Y** **N** If yes, please circle the type(s):

Cigarettes Cigars Pipe Snuff/chewing tobacco Other: _____

How much tobacco do you use/smoke per day? _____ or per week? _____ or per month? _____

If you used tobacco products in the past, when did you quit? _____

Do you drink any alcohol? **Y** **N**

If yes: how many alcoholic drinks per day? _____or per week? _____or per month? _____

Sleep History

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

1. During the past month, when have you usually gone to bed?

Usual WORKDAY Bed Time _____ Usual NON-WORKDAY Bed Time _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep?

NUMBER OF MINUTES _____

3. During the past month, when have you usually gotten up?

Usual WEEKDAY Getting Up Time _____ Usual WEEKEND Getting Up Time _____

4a. During the past month, how many hours of actual sleep did you get at night on weekdays and weekends? (This may be different than the number of hours you spend in bed)

WORKDAY Hours of Sleep per Night _____ NON-WORKDAY Hours of Sleep per Night _____

4b. If you could regularly get as much sleep as you wanted in one night, how much sleep would you prefer to get? HOURS OF SLEEP PER NIGHT _____

During the past month, how would you rate your sleep quality overall?

Very Good Fairly Good Fairly Bad Very Bad

Is your sleep restful? **Y** **N**

Do you have a bed partner or roommate? **Y** **N**

Have you been told you snore loud? **Y** **N**

Has anyone noticed that you stop breathing during your sleep? **Y** **N**

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation Chance of Dozing (0-3)

1. Sitting and reading _____
2. Watching TV _____
3. Sitting inactive in a public place (e.g. a theatre or a meeting) _____
4. As a passenger in a car for an hour without a break _____
5. Lying down to rest in the afternoon when circumstances permit _____
6. Sitting and talking to someone _____
7. Sitting quietly after a lunch without alcohol _____
8. In a car, while stopped for a few minutes in traffic _____

Weight Loss Information

What is your reason for seeking treatment at this time? _____

_____

_____

What has been your lowest body weight as an adult? _____

What has been your heaviest body weight as an adult? _____

When did you start to gain weight? _____

Any notable life/health event associated with your weight gain (such as college, pregnancy, marriage, divorce, death in the family, new health condition or treatment which may have affected your weight)?

_____

_____

Past Weight Loss Programs

Program/ Treatment Name	# Of Times?	When?	How Long In Program?	Amt. of Weight Loss?	How Long Kept Weight Off?	Pros And Cons Of Program/ Treatment For You?
Weight Watchers						
Medifast						
Medi-Weight Loss						
Jenny Craig						
NutriSystem						
L.A. Weight Loss						
Herbalife						
Weight loss Research Study						
Atkins						

Program/ Treatment Name	# Of Times?	When?	How Long In Program?	Amt. of Weight Loss?	How Long Kept Weight Off?	Pros And Cons Of Program/ Treatment For You?
South Beach						
Dietitian/ nutritionist						
Bariatric surgery						
Personal trainer						
Dieting on your own						
Exercising on your own						
Other weight loss program:						
Orlistat/ Xenical						
Meridia						
Alli						
Phentermine/ Adipex						

Program/ Treatment Name	# Of Times?	When?	How Long In Program?	Amt. of Weight Loss?	How Long Kept Weight Off?	Pros And Cons Of Program/ Treatment For You?
Fen-Phen						
Belviq						
Qsymia						
Contrave						
Saxenda						
Over-the-counter weight loss products (include name)						
Over-the-counter weight loss products (include name)						

What is your:

1) Ideal weight: _____

2) Happy weight:_____

3) Acceptable weight: _____

4) Unacceptable weight: _____

What makes it hard for you to lose weight and keep it off? _____

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes to lose weight at this time?

1 2 3 4 5

On a scale of 1 (not confident) to 5 (very confident), how confident are you in losing weight at this time?

1 2 3 4 5

Nutrition Information

In your opinion which of the following contributes to your excess weight? Please circle which apply.

Larger than normal portions

High sugar food choices

High fat food choices

Meal skipping

Sugary beverages? If yes, please specify type and amount of sugary beverages, including alcoholic drinks as they contain sugar

_____

_____

Lack of knowledge in healthy eating

Lack of time for meals preparation

Emotional eating/Stress eating

Lack of exercise

Medications

Other:

How willing are you to make changes in your diet? On a scale from 1-5 with 5 being the most willing, please assign a number.

1 2 3 4 5

How confident are you that you can make successful changes to your diet? On a scale from 1-5 with 5 being the most confident, please assign a number.

1 2 3 4 5

Are you interested in learning about:

Dietary education	Yes	No	Maybe
Exercise education	Yes	No	Maybe
Weight loss medications	Yes	No	Maybe
Weight loss surgery	Yes	No	Maybe

Other :

Please describe some of your personal barriers to eating healthy meals.

_____

_____

Please list any religious practices that affect your health care or diet: _____

Eating Questionnaire

Please carefully complete all questions, choosing NO or 0 for questions that do not apply.

1. During the past three months, have there been times when you have eaten what other people would regard as an unusually large amount of food (e.g., a pint of ice cream) given the circumstances? **Y** **N**

2. During the times when you ate an unusually large amount of food, did you experience a loss of control (e.g., felt you couldn't stop eating or control what or how much you were eating? **Y** **N**

3. How many times per month on average over the past three months have you eaten an unusually large amount of food and experienced a loss of control?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

During episodes of overeating with a loss of control, did you...

4. Eat much more rapidly than normal? **Y** **N**

5. Eat until you felt uncomfortably full? **Y** **N**

6. Eat large amounts of food when you didn't feel physically hungry? **Y** **N**

7. Eat alone because you were embarrassed by how much you were eating? **Y** **N**

8. Feel disgusted with yourself, depressed, or very guilty after overeating? **Y** **N**

9. If you have episodes of uncontrollable overeating, does it make you very upset? **Y** **N**

In order to prevent weight gain or counteract the effects of eating, how many times per month on average over the past three months have you:

10. Made yourself vomit?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

11. Used laxatives or diuretics?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

12. Fasted (skipped at least two meals in a row)?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Over the past 3 months...	Not at all		Slightly		Moderately		Extremely
13. Has your weight or shape influenced how you judge yourself as a person?	0	1	2	3	4	5	6
14. How much do eating or body image problems impact your relationships with friends and family, work performance, and school performance?	0	1	2	3	4	5	6

Do you obtain second helpings? **Y** **N** **Sometimes**

Do you sometimes eat when not hungry? **Y** **N** **Sometimes**

How often? _____ Per Day?_____ Per Week?_____

In a given week, how many times do you eat food not prepared by you or a family member? (i.e. from cafeteria, restaurant, coworker, etc.) _____

Three Days Food Recall

Please provide specific details regarding your diet this past month. Please in the charts below log your food intake for 2 consecutive weekdays and 1 weekend day. Provide food items and amounts. Instead of writing "sandwich," describe the sandwich. For example: 2 slices rye bread, 3 slices turkey, smear of mayo and mustard, lettuce, tomato.

PLEASE INCLUDE THE TIME (second column). Write "None" if you did not eat that meal or snack

Weekday #1

	Time	Food Eaten (Please specify amount)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Any additional food/drink intake beside meals/snacks above		

Weekday #2

	Time	Food Eaten (Please specify amount)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Any additional food/drink intake beside meals/snacks above		

One Weekend Day

	Time	Food Eaten (Please specify amount)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Any additional food/drink intake beside meals/snacks above		

Physical Activity Information

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercise do you do? _____

_____

How often and for how long do you participate? _____

_____

What is or would be your preferred exercise?

_____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain. _____

_____

_____

What gets in the way of you consistently engaging in physical activity/exercise? _____

_____

_____

How many hours of television do you watch every day? (circle one)

less than 1 hour (minimal) 1-2 hours 3-4 hours over 5 hours

Do you have a sedentary job (if applicable)? **Y** **N**

On a scale of 1 (not ready) to 5 (very ready), how ready are you to begin exercising?

1 2 3 4 5

On a scale of 1 (not confident) to 5 (very confident), how confident are you in engaging in physical activity?

1 2 3 4 5

DEBQ- EE scale

	1 - Never	2 - Seldom	3 - Sometimes	4 - Often	5 - Very Often
1. Do you have the desire to eat when you are irritated?					
2. Do you have a desire to eat when you have nothing to do?					
3. Do you have a desire to eat when you are depressed or discouraged?					
4. Do you have a desire to eat when you are feeling lonely?					
5. Do you have a desire to eat when somebody lets you down?					
6. Do you have a desire to eat when you are cross/angry?					

	1 - Never	2 - Seldom	3 - Sometimes	4 - Often	5 - Very Often
7. Do you have a desire to eat when you are expecting something unpleasant to happen?					
8. Do you have the desire to eat when you are anxious, worried, or tense?					
9. Do you have a desire to eat when things are going against you or when things have gone wrong?					
10. Do you have a desire to eat when you are frightened?					
11. Do you have a desire to eat when you are disappointed?					
12. Do you have a desire to eat when you are emotionally upset?					
13. Do you have a desire to eat when you are bored or restless?					