UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT QUESTIONNAIRE
UCLA FIT FOR HEALTHY WEIGHT PROGRAM

Note: Please write legibly in black ink. The first two pages of this form should be filled out primarily by a parent. The remainder of the form should be filled out by the patient with parental assistance depending on age and situation. Include additional pages as needed.

PARENT SECTION

Birth History

Birth Weight? _____ Term of Pregnancy (if known): Full Term / Premature (_____weeks)
Maternal Complications (maternal diabetes, hypertension, preeclampsia, twins)? _____
Birth Complications? _____ No. of Months Breastfed? _____

PAST MEDICAL & SURGICAL HISTORY (hospitalizations, illnesses, surgeries, accidents):

Date of last menstrual period: _____

FAMILY HISTORY (Check or list all medical problems and weight for all family members and for all other individuals living in the patient's home.)

	Height (ft/in)	Weight (lb/kg)	Lives in patient's home?	Age (now or at death)	Over-weight	Heart Disease	Diabetes	High Blood Pressure	Other: Cancer, Depression,Stroke, Bleeding,Clotting, Liver, Gallstones, etc.
Father									
Mother									
Brothers:									
Sisters:									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									

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REVIEW OF SYSTEMS (Check all that apply.)

CONSTITUTIONAL
- ☐ Fever
- ☐ Night sweats
- ☐ Chills
- ☐ Loss of weight
- ☐ Gain of weight
- ☐ Weakness

SKIN
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Dryness
- ☐ Birthmarks
- ☐ Stretch marks
- ☐ Skin discoloration
- ☐ Acne

EYES
- ☐ Eye infections
- ☐ Visual changes
- ☐ Crossed eyes

NEUROLOGICAL
- ☐ Headache
- ☐ Convulsions
- ☐ Paralysis
- ☐ Numbness
- ☐ Dizziness

RESPIRATORY
- ☐ Wheezing
- ☐ Persistent coughing
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Other

ENMT
- ☐ Ear infections
- ☐ Difficulty hearing
- ☐ Nosebleed
- ☐ Snoring
- ☐ Sinus problems
- ☐ Bleeding gums
- ☐ Difficult to swallow
- ☐ Hoarseness
- ☐ Mouth breathing

ENDOCRINE
- ☐ Often thirsty
- ☐ Often urinating
- ☐ Thyroid enlargement
- ☐ Heat/cold intolerance
- ☐ Osteoporosis
- ☐ Elevated blood sugar
- ☐ Insulin resistance

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Rapid heartbeat
- ☐ Swelling of arms /legs
- ☐ Pale or blue lips /skin
- ☐ Elevated lipids

IMMUNO/ALLERGIC
- ☐ Persistent infections
- ☐ HIV exposure
- ☐ Food allergies

GASTROINTESTINAL
- ☐ Heartburn /regurgitation
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Hemorrhoids
- ☐ Yellow skin/eyes
- ☐ Lack of stool control
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Fatty liver
- ☐ Dark stools
- ☐ H.pylori/ulcers

GENITOURINARY
- ☐ Frequent urination
- ☐ Leak urine with cough
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Lack of bladder control
- ☐ Bulging in groin

HEME/LYMPH
- ☐ Swollen glands
- ☐ Anemia
- ☐ Sickle cell
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Blood transfusions

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot pain
- ☐ Muscle pain /weakness
- ☐ Other pain
- ☐ Broken bones
- ☐ Bow legs
- ☐ Club foot

EMOTIONAL HEALTH
- ☐ Anxiety/nervousness
- ☐ Substance abuse
- ☐ Day/night wetting
- ☐ Depression/suicide
- ☐ Hyperactivity
- ☐ Aggression
- ☐ Non-compliant
- ☐ Habits/tics

BREAST/CHEST
- ☐ Lumps
- ☐ Swelling
- ☐ Tenderness

MALES
- ☐ Lump in testicles
- ☐ Penis discharge/sore

FEMALES
- ☐ Vaginal discharge
- ☐ Menstrual pain
- ☐ Abnormal bleeding
- ☐ Birth control pills

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MEDICATIONS (Include Over the Counter Medications)

Medication	Amount	# per Day	Medication	Amount	# per Day

ALLERGIES

Medication/Food Allergies & Reaction	Medication/Food Allergies & Reaction

PATIENT SECTION (Parental assistance may be required)

GENERAL

How did you hear about this program?

_____

What do you hope to achieve with the UCLA Fit for Healthy Weight Program?

_____

What is your greatest fear about this weight loss program?

_____

What is your goal weight? _____

How long do you think it will take for you to achieve your goal? _____

Have you successfully lost weight in the past? ☐ Yes ☐ No
If yes, how much weight? _____ How did you lose the weight? _____

On a scale from 0 to 5 where 0 = not ready and 5 = very ready:
How ready are *you* to make the changes necessary to lose weight? #_____

How ready are *your parent(s)/guardian(s)* to help you make these changes?
Name_____ #_____ Name_____ #_____

Have you considered weight-loss surgery? ☐ Yes ☐ No

Do you have a friend or family member who has had weight-loss surgery? ☐ Yes ☐ No
If yes, Who? _____ Why? _____

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HOME INFORMATION

Who lives with you? _____

What is the primary language spoken at home? _____

What are the methods of discipline used in your house (for example, grounding, taking away privileges, spanking, time outs, yelling)? _____

Do you help care for any relatives? ☐ Yes ☐ No
If yes, who? _____ How often? _____

Do you have pets? ☐ Yes ☐ No If yes, please list all _____

SCHOOL

What grade are you in? _____

What school do you go to? _____

What are your favorite and least favorite subjects in school? _____

Do you miss/skip/cut any classes? ☐ Yes ☐ No

What do you do after school? _____

Do you have a best friend? ☐ Yes ☐ No

Have you been in trouble? ☐ Detention ☐ Suspension ☐ Expulsion ☐ Other _____

What do you want to be when you grow up? _____

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NUTRITION

	None	1-3 times during the past 7 days	4-6 times during the past 7 days	1 time per day	2 times per day	3 times per day	4 or more times per day
1. During the past 7 days, how many times did you drink **100% fruit juices** such as orange juice, apple juice, or grape juice? (Do **not** count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks)	☐	☐	☐	☐	☐	☐	☐
2. During the past 7 days, how many times did you eat **fruit**? (Do **not** count fruit juice.)	☐	☐	☐	☐	☐	☐	☐
3. During the past 7 days, how many times did you eat **green salad**?	☐	☐	☐	☐	☐	☐	☐
4. During the past 7 days, how many times did you eat **potatoes**? (Do **not** count french fries, fried potatoes, or potato chips.)	☐	☐	☐	☐	☐	☐	☐
5. During the past 7 days, how many times did you eat **carrots**?	☐	☐	☐	☐	☐	☐	☐
6. During the past 7 days, how many times did you eat **other vegetables**? (Do **not** count green salad, potatoes, or carrots.)	☐	☐	☐	☐	☐	☐	☐
7. During the past 7 days, how many times did you drink a **can, bottle, or glass of soda or pop**, such as Coke, Pepsi, or Sprite? (Do **not** count diet soda or diet pop.)	☐	☐	☐	☐	☐	☐	☐
8. During the past 7 days, how many times did you drink **a can, bottle, or glass of a sports drink** such as Gatorade or PowerAde? (Do **not** count low-calorie sports drinks such as Propel or G2.)	☐	☐	☐	☐	☐	☐	☐

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9. During the past 7 days, how many times did you drink **a bottle or glass of plain water**? (Count tap, bottled, and unflavored sparkling water.)	☐	☐	☐	☐	☐	☐	☐
10. During the past 7 days, how many **glasses of milk** did you drink? (Count the milk you drank in a glass or cup, from a carton, or with cereal. Count the half pint of milk served at school as equal to one glass.)	☐	☐	☐	☐	☐	☐	☐
11. During the past 7 days, on how many days did you eat **breakfast**?	☐	☐	☐	☐	☐	☐	☐
12. During the past 7 days, how many times did you eat **fast food**? (Count fast food meals eaten at school, at home or at fast-food restaurants, carryout or drive thru.)	☐	☐	☐	☐	☐	☐	☐

Source: CDC Youth Risk Behavior Surveillance System, 2015

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PHYSICAL ACTIVITY

The next 6 questions ask about physical activity.

1. During the past 7 days, on how many days were you physically active for a total of **at least 60 minutes per day**? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.)

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

2. During the past 7 days, on how many days did you do exercises to **strengthen or tone your muscles**, such as push-ups, sit-ups, or weight lifting?

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

3. On an average school day, how many hours do you watch TV?

- ☐ I do not watch TV on an average school day
- ☐ Less than 1 hour per day
- ☐ 1 hour per day
- ☐ 2 hours per day
- ☐ 3 hours per day
- ☐ 4 hours per day
- ☐ 5 or more hours per day

4. On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Count time spent on things such as Xbox, PlayStation, an iPod, an iPad or other tablet, a smartphone, YouTube, Facebook or other social networking tools, and the Internet.)

- ☐ I do not play video or computer games or use a computer for something that is not school work
- ☐ Less than 1 hour per day
- ☐ 1 hour per day
- ☐ 2 hours per day
- ☐ 3 hours per day
- ☐ 4 hours per day
- ☐ 5 or more hours per day

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5. In an average week when you are in school, on how many days do you go to physical education (PE) classes?
   - ☐ 0 days
   - ☐ 1 day
   - ☐ 2 days
   - ☐ 3 days
   - ☐ 4 days
   - ☐ 5 days

6. During the past 12 months, on how many sports teams did you play? (Count any teams run by your school or community groups.)
   - ☐ 0 teams
   - ☐ 1 team
   - ☐ 2 teams
   - ☐ 3 or more teams

Source: CDC Youth Risk Behavior Surveillance System, 2015

PSYCHOLOGICAL/EMOTIONAL

For the next 25 questions, please put a check mark below the word that shows how often each of these things happen to you. There is no right or wrong answer.

	Never	Sometimes	Often	Always
1. I feel sad or empty.	☐	☐	☐	☐
2. I worry when I think I have done poorly at something.	☐	☐	☐	☐
3. I would feel afraid of being on my own at home.	☐	☐	☐	☐
4. Nothing is much fun anymore.	☐	☐	☐	☐
5. I worry that something awful will happen to someone in my family.	☐	☐	☐	☐
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds).	☐	☐	☐	☐
7. I worry what other people think of me.	☐	☐	☐	☐
8. I have trouble sleeping.	☐	☐	☐	☐
9. I feel scared if I have to sleep on my own.	☐	☐	☐	☐
10. I have problems with my appetite.	☐	☐	☐	☐
11. I suddenly become dizzy or faint when there is no reason for this.	☐	☐	☐	☐
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).	☐	☐	☐	☐

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	Never	Sometimes	Often	Always
13. I have no energy for things.	☐	☐	☐	☐
14. I suddenly start to tremble or shake when there is no reason for this.	☐	☐	☐	☐
15. I cannot think clearly.	☐	☐	☐	☐
16. I feel worthless.	☐	☐	☐	☐
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening.	☐	☐	☐	☐
18. I think about death.	☐	☐	☐	☐
19. I feel like I don't want to move.	☐	☐	☐	☐
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of.	☐	☐	☐	☐
21. I am tired a lot.	☐	☐	☐	☐
22. I feel afraid that I will make a fool of myself in front of people.	☐	☐	☐	☐
23. I have to do some things in just the right way to stop bad things from happening.	☐	☐	☐	☐
24. I feel restless.	☐	☐	☐	☐
25. I worry that something bad will happen to me.	☐	☐	☐	☐

Source: Revised Child Anxiety and Depression Scale- Short Version

Please skip to SLEEP if you are <12 years old:

Have you considered doing harm to yourself? ☐ Yes ☐ No

Have you ever thought about suicide? ☐ Yes ☐ No

Has anyone in your family been depressed or attempted suicide? ☐ Yes ☐ No

Do you: ☐ Drink alcohol ☐ Smoke cigarettes ☐ Use drugs

Do any of your family members: ☐ Drink alcohol ☐ Smoke cigarettes ☐ Use drugs

SLEEP

How many hours do you sleep:
Weekdays, per night? _____ Weekends, per night? _____ Nap, per day? _____

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:

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(0 – would *never* doze, 1 – *slight* chance of dozing, 2 – *moderate* chance of dozing, 3 – *high* chance of dozing)

Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (e.g. theater)	_____
As a passenger in a car for an hour without break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

TOTAL SCORE (Add the number of above to get total). _____

(What does your score mean? 1 to 6 Good Sleep; 7 to 8 Average; 9-24 Very Sleepy)

YOUR PHYSICIANS Include the name, address and phone number of your physicians including primary care doctor, endocrinologist, gastroenterologist, pulmonologist, surgeon, and/or psychologist (if applicable).

Name of Doctor	Address	Phone Number

I certify that the above information is correct to the best of my knowledge.

Patient or Representative Signature_____

Date_____Time_____

If signed by someone other than the patient, please specify relationship to patient _____

Interpreter Signature _____ID#_____Date_____Time_____

Physician Signature _____ID#_____Date_____Time_____

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Bring COMPLETED Registration Form to your initial visit.

UCLA FIT FOR HEALTHY WEIGHT PROGRAM
200 MEDICAL PLAZA, SUITE 265
LOS ANGELES, CA 90095-6900
www.fitprogram.ucla.edu
Fax Number: 310-206-3566
Phone Number: 310-825-6469

OFFICE USE ONLY

*Reviewing Physician:*_____ *Date*_____ *Time*_____

Psychologist: _____ Date_____ Time _____

Dietitian: _____ Date_____ Time _____

Physical Therapist: _____ Date_____ Time_____