Bartels Medical Associates, PLLC

**Medical Weight Control**

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Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Home Phone:

Address: Office Phone:

Birthdate: Age: Height: (no shoes) Present Weight:

Desired Weight: Birth Weight: Weight at age 20: Weight 1 year ago:

Occupation: Physical Activity at Work:

Physical Activity at Home:

Sports and Athletic interests:

Describe any Medical Problems:

Past diets you followed-type?

Results?

Food Allergies: Food Dislikes:

Other Allergies: Who plans meals? Cooks?

Shops? Shopping list used? How often do you eat out?

Do you drink alcohol? What? How much daily? Weekly?

Describe usual energy level: Foods you crave?

When? (time of day) Do you awaken hungry at night?

What do you do? What are your worst food habits?

Please describe your general health goals & the improvements you wish to make:

\*Please turn over and complete back

Family Members Overweight?

(relationship) State of Health No, Slight, Moderate, very

Typical Breakfast Typical Lunch Typical Dinner

Time Eaten: Time Eaten: Time Eaten:

Where: (Home,

Café, etc.) Where: Where:

With Whom: With Whom: With Whom:

Snack Habits: What? How Much? When:

Why did you have each snack at the time? (hunger, boredom, coffee break, etc.)

Please use your own words when answering this:

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