John La Puma, MD, FACP

# Metabolic Pattern Analysis and Assessment Tool

CHEF CLINIC

Please help us learn a little about you. Please answer as completely as you can, and **print your name and the date on each sheet**. Thank you.

**Date**_____ **Name** (*Please Print)* _____

**1.** Please write why you are here today.

**2.** What specific question(s) do you want to have answered today?

If you **DO NOT** intend to lose weight, please skip to item **#15**.

3. What are the **MAIN REASONS** you want to lose weight? (***RANK the choices below by number:(1 is MOST IMPORTANT and 6 is LEAST IMPORTANT***)

To look and feel better_____ Family and friends want me to_____
To set a good example for my family_____ My doctor told me to_____
To help control current health problems_____ To avoid future health problems_____

**4.** What do you think is a **reasonable** target weight/dress size/belt size? _____pounds/size

**5.** What was the weight/size when you graduated from **high school**? _____pounds/size

**6.** When (**month, year**) did the weight gain start? _____month, year weight gain started

**7.** What is the **lowest** weight/dress or belt size you have maintained for at least 1 year as an adult? During which year? _____pounds/size _____year

**8.** When you were at this low weight, what was the **most important thing** you did to keep your weight low? (***CIRCLE ONLY ONE***)

Changed the way I ate Got support from others Attended a program
Exercised Took a medication Other _____

**9.** Compared to your past attempts, **how motivated** are you to lose weight this time? (***CIRCLE ONLY ONE***)

Much less motivated About as motivated Much more motivated
Slightly less motivated More motivated

**10.** Is there someone in your life who will be supportive of your efforts to lose weight? ___**Yes** ___**No**

If Yes, who? What is his/her relationship to you? _____

**11.** Have you ever purged (used laxatives, diuretics, or induced vomiting) to control your weight? (***CIRCLE YES OR NO)***

**Yes** **No**

**Date**_____ **Name** (*Please Print)* _____

**12.** In the last 10 years, have you used Drugs or Supplements to lose weight? If so, which, and for how long? ***(CIRCLE EACH APPROACH YOU USED)****(LIST ALL)*
Over the Counter Drugs_____How long?_____
Prescription Drugs _____How long?_____

**13.** Which, if any, of the following are true of your eating habits? (***CIRCLE the TRUE statements, if any***)
I often eat when I am lonely or bored.
I often eat for pleasure, using food as a reward.
I often eat to help me deal with the stresses of home.
I often eat to help me deal with the stresses of work.
I am more likely to overeat when I am out with friends or in social situations.
I am more likely to overeat when I am drinking alcohol.

**14.** Who usually shops for and prepares the food in your home? (***CIRCLE ONLY ONE***)
I usually shop for and prepare the food.
I usually shop for the food, but someone else usually prepares it.
Someone else usually shops for the food, but I usually prepare it.
Someone else usually shops for and prepares the food.
I generally do not eat at home.

**15.** On average how many breakfasts do you skip in a week?
_____**BREAKFASTS SKIPPED PER WEEK**

**16.** On average, how many lunches do you skip in a week?
_____**LUNCHES SKIPPED PER WEEK**

**17.** How many times do you eat during the day, including snacks? _____**TIMES YOU EAT DAILY**

**18.** How many times weekly do you eat out, including snacks? ____**TIMES WEEKLY YOU EAT OUT**

**19.** When you go out to eat, what two dishes do you order **MOST OFTEN**?
**1.** _____ **2.** _____

**20.** How many minutes do you spend cooking your main meal daily?
_____**MINUTES COOKING YOUR MAIN MEAL DAILY**

**21.** Which are the three foods you eat **MOST OFTEN** as snacks?
**1.** _____
**2.** _____
**3.** _____

**22.** About how many hours per week do you watch television and eat at the same time?
_____**TV HOURS WATCHED PER WEEK WHILE EATING**

**23. Have you had or do you have…? (CIRCLE ALL THAT APPLY)**

| | | | | |
|---|---|---|---|---|
| Arthritis | Heart Disease | High Triglycerides | Psychiatric Problems | Cancer, any kind |
| Asthma | High Blood Pressure | Operations, any kind | Stroke | Other important |
| Diabetes | High Cholesterol | Back or Knee Injury | Thyroid Problems | problems |

**23.** Do any diseases run in your family? If so, which?_____

 

24. Do you have kids? Names? Ages?_____

25. Do you use any of the following? (CIRCLE ALL THAT APPLY)
Coffee/Tea: How many cups per day?___?___ Energy Drinks/Soda: How many per day ?____/___
Cigarettes: ____# per day ____# of years Alcohol _____ Which?

26. Do you presently have a regular exercise program? ____yes ____no

if yes, please describe:_____

27. Have you ever had an exercise-related injury? ____yes ____no

if yes, please describe:_____

28. Have you ever had an exercise stress test? ____yes ____no If yes, date/location:
_____

**29. PLEASE CIRCLE the number of any statement that applies to you.**
Lifestyle

1. I eat out 10 or more times in a week
2. I consume 14 or more alcoholic drinks in a week
3. I seldom eat more than 2 servings (combined) of fruit and vegetables daily.
4. I drink more than 20 ounces of soft drink/pop daily
5. I seldom exercise 60 minutes or more in a week.
6. I consume refined sugar/simple carbohydrates several times daily
7. I often eat between meals
8. I eat foods such as burgers, hot dogs, commercial pizza, fried chicken, fries, chips almost daily.
9. I have a problem with stress eating or compulsive eating.

Total Circled_____

Syndrome X

1. Someone in my family or my family history has Diabetes Mellitus.
2. I have been told I have high triglycerides in the blood.
3. If female, I have had infertility, unwanted facial hair, or ovarian cysts.
4. If female, I had gestational diabetes or delivered a baby weighing more than 9 pounds.
5. I often crave sugar or sugary treats.
6. I experience erratic energy levels and mood swings, sometimes affected by eating.
7. I gain weight in the upper body or "apple" distribution—around the middle.
8. I have been told I have borderline high blood pressure or actually have high blood pressure.
9. I have had gout, or have gout.
10. My ethnic heritage is non-European.

Total Circled_____

**30.** How did you first hear about Dr. La Puma? (***Please CHECK One and SPECIFY***)
Newspaper(**WHICH?**)_____ Magazine(**WHICH?**)_____
Friend(**WHO?**)_____ Radio?(**WHICH?**)_____
Class/Conference(**WHICH?**)_____ TV Show(**WHICH?**)_____
World Wide Web(**WHICH?**)_____ Health Professional Referral(**WHO?**)_____

**Thank you!**