OVERWEIGHT/OBESITY

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

Gender : Male Female

E-Mail :

Phone Number :

WEIGHT AND FAMILY HISTORY

Height (in inches or centimeters):

Current Weight (in pounds or kilograms):

Do you know if your BMI is 25% or higher? Yes No

Have you been diagnosed with any obesity-related conditions, such as diabetes or high blood pressure?

Yes If yes, how long have you been aware of this?

No

Do you have a family history of obesity or related conditions? Yes No Not sure

LIFESTYLE AND DIETARY HABITS

How would you describe your typical diet?

Balanced and healthy High in processed foods High in sugary snacks and beverages

Other (please specify): ______________________________

How often do you engage in moderate to vigorous physical activity per week?

Rarely or never 1-2 days 3-4 days 5 or more days

Do you have a regular eating schedule, or do you often skip meals?

How much water do you typically drink in a day?

How often do you consume sugary beverages (sodas, energy drinks, sweetened teas)?

Do you consume alcoholic beverages? If yes, how often and in what quantities?

THANK YOU FOR YOUR INFORMATION

OVERWEIGHT/OBESITY

SCREENING FORM

SYMPTOMS

Are you experiencing any of the following symptoms associated with obesity?

- ☐ **Difficulty breathing**
- ☐ **Joint pain**
- ☐ **Fatigue**
- ☐ **Sleep disturbances**
- ☐ **Other (please specify):** ____________________

PSYCHOSOCIAL FACTORS

Do you experience stress, anxiety, or depression related to your weight or body image?

☐ **Yes** ☐ **No**

WEIGHT LOSS ATTEMPTS

Have you attempted to lose weight in the past year?

☐ **Yes, successfully** ☐ **Yes, unsuccessfully** ☐ **No**

ADDITIONAL INFORMATION

Have you consulted with a healthcare professional or nutritionist about your weight?

☐ **Yes** ☐ **No**

If you have concerns about obesity or related symptoms, contact us now for further evaluation and guidance.

THANK YOU FOR YOUR INFORMATION