Please read the following important information before submitting your forms:

1. **All sections of the Patient Medical History Form must be completed to process your application.**
2. **When completing any section with a yes or no answer, either a yes or no must be marked. A non-answer cannot be interpreted as a no.**
3. **All current medications taken, and their indications must be included on this form. We will not get this information from your UC Health chart.**

Any incomplete forms will be mailed back to the patient for completion prior to checking insurance benefits and scheduling any appointments.

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Patient Medical History Form

Today's Date: _____

PATIENT INFORMATION

Height: _____ Weight: _____ BMI: _____

Patient's last name: _____ First: _____ Middle: _____ ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms ☐ Dr.

Hearing impaired? yes no Visually impaired? yes no Other limitations? _____

Medical transport required? yes no Need interpreter? yes no Language: _____

Marital status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? _____

(Former name): _____ Birth date: _____ Age: _____ Sex: ☐ M ☐ F

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

What number do you prefer to be contacted? ☐ Home ☐ Cell ☐ Work

E-Mail Address: _____

Occupation: _____ Employer: _____

REQUIRED INSURANCE INFORMATION

Please indicate primary insurance: _____

Subscriber's name: _____ Member ID # _____

Phone # for Providers: _____ Subscriber's S.S.#: _____

Occupation: _____ Employer: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse

Name of secondary insurance (if applicable): _____

Subscriber's name: _____

Subscriber's name: _____ Member ID # _____

Phone # for Providers: _____ Subscriber's S.S.#: _____

PROGRAM INFORMATION

Date Seminar Attended: _____

How did you hear about us? (Please check one box):

☐ Physician ☐ Insurance plan ☐ Hospital ☐ Family/Friend ☐ TV ☐ WEB ☐ Other _____

I am interested in:

☐ **NON SURGICAL MEDICAL WEIGHT LOSS** ☐ **RETURNING TO NON SURGICAL MEDICAL WEIGHT LOSS**

☐ **SURGERY** *(please choose a surgical procedure in which you are interested)*

- ☐ Gastric sleeve surgery
- ☐ Gastric band surgery (LapBand)
- ☐ Revision: (Please explain) _____
- ☐ Gastric balloon
- ☐ Gastric bypass surgery

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Primary Care Provider			
First Name:	Last Name:		☐ MD ☐ DO ☐ APRN ☐ PA
Street Address:			
City:	State:	Zip:	Phone:
Cardiologist			
First Name:	Last Name:		☐ MD ☐ DO ☐ APRN ☐ PA
Street Address:			
City:	State:	Zip:	Phone:
Pulmonologist			
First Name:	Last Name:		☐ MD ☐ DO ☐ APRN ☐ PA
Street Address:			
City:	State:	Zip:	Phone:
Psychological Services			
First Name:	Last Name:		☐ MD ☐ DO ☐ APRN ☐ PA
Street Address:			
City:	State:	Zip:	Phone:
Other Specialist			
First Name:	Last Name:		☐ MD ☐ DO ☐ APRN ☐ PA
Street Address:			
City:	State:	Zip:	Phone:

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Past/Present Medical History

Please circle the appropriate response:

Diabetes	yes	no	past	present	Emphysema/COPD	yes	no	past	present
Age at onset of diabetes: _____					Pneumonia	yes	no	past	present
If yes to diabetes, diabetes control	good	poor	past	present	Arthritis	yes	no	past	present
Type I Diabetes	yes	no	past	present	If yes to arthritis, where:	yes	no	past	present
Type II Diabetes	yes	no	past	present	_____				
Diabetes while pregnant	yes	no	past	present	Problems with anesthesia	yes	no	past	present
Hypertension (high blood pressure)	yes	no	past	present	Thrombophlebitis	yes	no	past	present
High cholesterol or triglycerides	yes	no	past	present	Abnormal Bleeding	yes	no	past	present
Heart attack	yes	no	past	present	Rheumatic fever	yes	no	past	present
Congestive heart failure	yes	no	past	present	Thyroid problems	yes	no	past	present
Coronary heart disease	yes	no	past	present	Tuberculosis	yes	no	past	present
Heart murmur	yes	no	past	present	Urinary tract infections	yes	no	past	present
Ever taken Fen-Phen	yes	no	past	present	Kidney disease	yes	no	past	present
Varicose Veins	yes	no	past	present	Bladder/kidney infections	yes	no	past	present
Blood clots in the legs	yes	no	past	present	Hepatitis/cirrhosis	yes	no	past	present
Blood clots to the lungs/Pulmonary embolism	yes	no	past	present	AIDS/HIV	yes	no	past	present
					Do you have to take antibiotics before dental work?	yes	no	Past	Present
PCOS (Polycystic ovarian syndrome)	yes	no	past	present					
Stroke	yes	no	past	present	Colitis/enteritis/Crohn's Disease	yes	no	past	present
Asthma	yes	no	past	present	Seizures	yes	no	past	present

Past Surgical History Please list all surgeries and approximate dates (year)	Past Hospitalizations Please list all hospitalizations and approximate dates (year)	Comorbidities office use only

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Past/Present Medical History (continued)

Psychiatric:
Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential.

Please check all that apply.

- ☐ Alcoholism / Substance abuse
- ☐ Anorexia
- ☐ Anxiety
- ☐ Attempted suicide
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Binge eating disorder
- ☐ Bipolar disorder ('manic- depression') type 1 or type 2
- ☐ Bulimia
- ☐ Depression
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia/Schizoaffective Disorder
- ☐ Sexual abuse (if yes, when _____)
- ☐ Mental/Emotional abuse (if yes, when _____)
- ☐ Physical abuse (if yes, when _____)
- ☐ Self injury or cutting behavior (if yes, when _____)
- ☐ Other psychiatric illness or condition? Please describe here: _____

Have you ever had outpatient psychiatric counseling?
Yes ☐ No ☐ If yes, for what condition(s)? _____

Have you ever been hospitalized for psychiatric problems?
Yes ☐ No ☐ If yes, when? _____

Are you currently seeing a counselor/psychiatric professional?
Yes ☐ No ☐ If yes, for what condition(s)? _____

Have you ever been in an alcohol or substance abuse program?
Yes ☐ No ☐ If yes, from: _____ to: _____

Are you currently taking medications for anxiety ('nerves'), depression or other mental health problems?
Yes ☐ No ☐

If yes, who is your prescriber?
Name: _____
Address: _____
Phone: _____

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Review of Systems

Please circle the appropriate response:

General		
Fevers	Yes	no
Sweats	Yes	no
Fatigue	yes	no
Loss of appetite	yes	no
Skin		
Rash	yes	no
Acne	yes	no
Skin cancer	yes	no
Skin Darkening	yes	no
Neck	yes	no
Underarms	yes	no
Groin	yes	no
Vision		
Visual problems	yes	no
Hearing		
Hearing problems	yes	no
Ear ringing	yes	no
Neurological		
Dizziness	yes	no
Migraines	yes	no
Frequent headaches	yes	no
Memory loss	yes	no
Shaking	yes	no
Numbness	yes	no
Incoordination	yes	no
Genito-urinary		
Blood in urine	yes	no
Vaginal infections	yes	no
Stress urinary incontinence	yes	no
Prostate infections	yes	no
Pulmonary Disease		
Short of breath on exertion	yes	no
Hay fever	yes	no
Bloody sputum	yes	no
Persistent cough	yes	no
Infection		
AIDS contact	yes	no
Swollen glands	yes	no
Recurring infections	yes	no
Skin infections	yes	no
Exercise Limitations		
Mild	yes	no
Moderate	yes	no
Severe	yes	No

Physical Activity Limitations		
Climbing stairs	yes	no
Unusual fatigue	yes	no
Airline travel	yes	no
Lifting from floor	yes	no
Tying shoelaces	yes	no
Playing with children	yes	no
Pain in joints		
Back	yes	no
Hips	yes	no
Knees	yes	no
Feet	yes	no
Gastrointestinal		
Heartburn/acid reflux	yes	no
Heartburn/acid reflux (5+ years)	yes	no
EGD/Stomach Scope	yes	no
If yes, when? _____		
Stomach pains	yes	no
Stomach ulcers	yes	no
Gastritis	yes	no
H. pylori infection	yes	no
Rectal Bleeding	yes	no
Liver disease	yes	no
Frequent diarrhea	yes	no
Frequent constipation	yes	no
Stomach surgery	yes	no
Sleep Apnea		
# of hours of sleep per night: _____		
Diagnosed sleep apnea	yes	no
If diagnosed sleep apnea date:_____		
Activity using oral appliance for mild sleep apnea	yes	no
CPAP/BIPAP prescribed	yes	no
Actively using CPAP/BIPAP	yes	no
Frequent waking at night	yes	no
Choking at night	yes	no
Aspiration/choking	yes	no
# of pillows used _____		
Cardiovascular		
Swelling of ankles	yes	no
Chest pain	yes	no
Have you had an echocardiogram?	yes	no

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Review of Systems (continued)

FOR FEMALES ONLY

Gynecological

Last menstrual period (date)_____

Pregnancies (yes / no) How many? _____

Number of living children _____

Current Menstrual Status *Circle appropriate response:*

Regular yes no

Irregular yes no

If no menstrual cycle, why

- ☐ Hysterectomy
- ☐ IUD
- ☐ Endometrial ablation
- ☐ Menopause
- ☐ Other _____
- ☐ Unknown _____

Please check the appropriate box for contraception method used:

- ☐ IUD
- ☐ Implant
- ☐ Diaphragm
- ☐ Condoms
- ☐ Depo shot
- ☐ OCP (oral contraceptive pill)
- ☐ Abstinence (no intercourse)
- ☐ Vasectomy
- ☐ Natural family planning method

Any chance you are currently pregnant? yes no

Are you intending pregnancy in the next two years? yes no

Epworth Sleepiness Scale

Please place a check in the appropriate box given each situation ranking your chance of dozing or sleeping	**0** **NEVER**	**1** **SLIGHT**	**2** **MODERATE**	**3** **HIGH**
Sitting and reading				
Watching TV				
Sitting inactive in a public space				
Being a passenger in a motor vehicle for an hour or more				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch (no alcohol)				
Stopped for a few minutes in traffic while driving				

Sleep Apnea Questionnaire

Please circle the appropriate response:

Collar size of shirt: S, M, L, XL, or _____ inches/cm

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors? yes no
2. Do you often feel tired, fatigued, or sleepy during daytime? yes no
3. Has anyone observed you stop breathing during your sleep? yes no
4. Do you have or are you being treated for high blood pressure? yes no
5. Neck circumference greater than 17 in? yes no

Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep, 1991; 14: 50-55

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Medications

List all daily medications including over-the-counter (aspirin, ibuprofen, Aleve, etc.), vitamins, herbs or supplements, and contraceptives
Please indicate NONE if no medications taken

Name	Dosage	Frequency	Reason

Do you take any of the following over-the-counter medications regularly?

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	no

Allergies

List any known food or medication allergies or sensitivities
Please indicate NONE if no medications taken

Allergy	Reaction

List any allergies or sensitivities to the following:

Substance			Reaction
Latex	yes	no	
Dye	yes	no	
Iodine	yes	no	
Tape	yes	no	

Other allergies:

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Social History

Religious preference _____
Ethnic background _____
Education _____
Number of people living in your home _____Who? _____
What type of work do you do? _____
What type of hobbies or activities do you do? _____

Please circle the appropriate response:

Do you currently smoke?	yes	no	
Have you ever smoked?	yes	no	Age started _____ Age last smoked _____ Avg cigarettes/day _____
Do you drink alcohol?	yes	no	Drinks per day _____ Days per week _____
Do you use marijuana?	yes	no	How often _____
Do you use recreational drugs	yes	no	If yes, what _____ How often _____
Do you abuse prescription drugs?	Yes	no	If yes, what _____ How often _____

On a scale of 1-10 how motivated are you to change your lifestyle? _____
How does your spouse, partner, family, friends, and significant others feel about your weight issues? _____
_____
_____

Weight History

Age you first became overweight _____
Highest adult weight (age 25 and older) _____ lbs
Weight comfortably maintained _____ lbs
Lowest adult weight (age 25 and older) _____ lbs

Please check all that apply:

Grew up:
- ☐ overweight
- ☐ normal weight
- ☐ active in sports
- ☐ under weight
- ☐ average weight

Weight gain after:
- ☐ moved
- ☐ marriage
- ☐ divorce
- ☐ separation
- ☐ quit smoking
- ☐ moved
- ☐ desk job
- ☐ injury
- ☐ gradual
- ☐ surgery

Non-Supervised Weight Loss Attempts

METHOD	CHECK HERE
None of the below apply	
Health spa	
High protein	
Hypnosis	
Low carbohydrate	
Low fat	
Calorie counting on my own	
Gym membership	
Home gym equipment	
Atkins Diet	

METHOD	CHECK HERE
None of the below apply	
Mayo Clinic Diet	
Pritikin	
Richard Simmons	
Scarsdale Diet	
Stillman Diet	
Sugar Busters	
Slim Fast	
South Beach Diet	
Other	

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Weight History (continued)

Supervised Weight Loss Attempts

None of the below apply	
Diet Pills From MD	
Diet Shots From MD/HCG	
Overeaters Anonymous	
Weight Watchers	
Health Management Resources (HMR)	
T.O.P.S.	
Jenny Craig	
New Direction	
Exercise Counseling	
Nutritional Counseling	

None of the below apply	
Supervised Calorie Counting	
Acupuncture	
Psychological Counseling	
Weight Loss Center	
Personal Trainer	
Medifast	
Metrical	
Nutri-System	
Optifast	
Other	

Weight Loss Medications

None of the below apply	
Acutrim	
Adipex-P	
Alli	
Amphetamines	
Anorex	
Belviq	
Benzphetamine	
Contrave	
Dexatrim	
Didrex	
Fastin	
Fenfluramine	
Qsymia	
Herbal Remedies	
Ionamin	
Liraglutide/Victoza/Saxenda	

None of the below apply	
Mazanor	
Meridia	
Metabolife	
Obalan	
Orlistat	
Phentermine	
Phenfen	
Plegine	
Pondimin	
Redux	
Sanorex	
Tenuate	
Wehless	
Xenical	
Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)	
Stomach stapling	
Vertical banded gastroplasty	

Gastric band	
Sleeve gastrectomy	
Other	

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Family Medical History:

Please indicate if you have a family history of the following:

Are you adopted? yes no

Parent(s): **Mother** ☐ alive ☐ deceased **Father** ☐ alive ☐ deceased

Sibling(s): **Brother(s):** How many alive? ___ How many deceased? ___ **Sister(s):** How many alive? ___ How many deceased?___

Children: How many alive? ___ How many deceased? ___

Please complete the below section if NOT adopted.

	Parent(s)		**Sibling(s)**		**Other Relatives** *cousins, aunts, grandparents, etc.*	**No Family History**	**Don't Know**
	Mother	*Father*	*Brother*	*Sister*			
Diabetes							
Heart Disease							
Hypertension							
Gallstones							
Obesity							
Sleep Apnea							
Asthma							
Cancer *(specify type)*							
Depression							
High Cholesterol							
Osteoporosis							
Stroke							
Chemical Dependency							
Alcohol Abuse							
Bipolar disorder							
Anesthesia Problems							
Schizophrenia							

Exercise History

Please place a check in the appropriate box:

Do you track and/or monitor your activity? yes ☐ no ☐
If yes, what do you use? (Fitbit, pedometer) _____
Do you exercise on a regular basis? yes ☐ no ☐
Are you able to perform exercises such as walking 3 blocks, swimming or using exercise bike? yes ☐ no ☐

Average time spent exercising:	**I don't do this**	**1x/week**	**2-3x/week**	**4-5x/week**	**6+x/week**	**Minutes/day**
Walking						
Stretching Exercise (yoga/pilates/bands, etc.)						
Weight Lifting						
Aerobic						
Other: _____						

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Exercise History (continued)

Physical limitations preventing exercise: *Please circle the appropriate response:*

Hip pain	yes	no	Back pain	yes	no
Knee pain	yes	no	Fatigue	yes	no
Ankle pain	yes	no	Excessive sweating	yes	no
Foot pain	yes	no	Shortness of breath	yes	no

Nutrition History

Please circle the appropriate response:

Do you track and/or monitor your calories or food intake? yes no

If yes, what do you use? (examples: MyFitnessPal, Spark People, etc.) _____

How often do you track calories or food intake? ☐ Daily ☐ 2 – 3 times a week ☐ 1 time a week or less

How many meals do you eat daily? _____

Do you snack between meals? yes no

Are you able to make your own food choices and control your food environment? yes no

Food Frequency

Estimated servings per day:	0-3 per day	3-6 per day	6-9 per day	10+ per day
Soda/sugary drinks/sweet tea/lemonade				
Sweets/deserts/candy				
Fried foods/fast food/chips/pizza				
Dairy products/cheese/etc.				
Carbs/breads/cereal/pasta				
Fruits/veggies				
Proteins				

Eating Behaviors

Chaotic eating patterns/not eating regular meal	yes ☐	no ☐	Preference snacking on:		
Sleepwalking & eating	yes ☐	no ☐	pretzels, chips, starches	yes ☐	no ☐
(such as waking up to see evidence of food consumed			sweets	yes ☐	no ☐
but no memory of having eaten it.)			large portion sizes	yes ☐	no ☐
Drinking sweetened beverages – pop, kool-aid, etc.	yes ☐	no ☐			
Emotional/stress eating	yes ☐	no ☐			

Other Weight Gain Contributing Factors

Decrease in activity after job change	yes ☐	no ☐	Smoking cessation	yes ☐	no ☐
Decreased activity after an injury	yes ☐	no ☐	Weight gain with pregnancy	yes ☐	no ☐
Genetics	yes ☐	no ☐	Yo-yo dieting	yes ☐	no ☐
Medications	yes ☐	no ☐			

Do you currently use or have used any of the following behaviors in the past 6 months to control your weight? (Check all that apply)

☐ Bingeing and then Vomiting

☐ Bingeing followed by food restriction

☐ Vomiting purposefully after eating ('bulimia')

☐ Excessive/Obsessive Calorie Restriction/Fasting ('anorexia')

☐ Excessive/Obsessive Exercise

☐ Laxative abuse

If so, when and how long was this period of behavior? _____

Current Eating:

Do you eat large meals in one sitting?	Yes ☐	No ☐	If yes, how frequent? _____
Do you frequently skip meals, or eat only 1-2 times per day?	Yes ☐	No ☐	If yes, how frequent? _____
Do you "graze" or snack frequently throughout the day/evening?	Yes ☐	No ☐	If yes, how frequent? _____
Do you eat or snack late in the evening or at night?	Yes ☐	No ☐	If yes, how frequent? _____

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Nutrition History (continued)

TYPICAL DAILY INTAKE

Please record the typical types of foods and the amounts you eat on a regular basis (must complete).

	Food Type	Amount Per Meal
Before Breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon snack		
Dinner		
After dinner		
Before Bed		

Check ONLY ONE statement under each question that best describes the way you feel on a typical day.

I feel…

0 ☐ I don't feel self-conscious about my weight or body size when I'm with others,
0 ☐ Concerned about how I look to others, but it normally does not make me feel disappointed with myself.
1 ☐ I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
3 ☐ Very self-conscious about my weight and frequently, I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.

I feel…

0 ☐ I don't have any difficulty eating slowly in the proper manner.
1 ☐ Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
2 ☐ At times, I tend to eat quickly and then, I feel uncomfortably full afterwards.
3 ☐ I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because I've eaten too much.

I feel…

0 ☐ Capable to control my eating urges when I want to.
1 ☐ Like I have failed to control my eating more than the average person.
3 ☐ Utterly helpless when it comes to feeling in control of my eating urges.
3 ☐ Helpless about controlling my eating I have become very desperate about trying to get in control.

I feel…

0 ☐ I don't have the habit of eating when I'm bored.
0 ☐ I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
0 ☐ I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.
2 ☐ I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.

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Nutrition History (continued)

Check ONLY ONE statement under each question that best describes the way you feel on a typical day.

I feel…
0 ☐ I'm usually physically hungry when I eat something.
1 ☐ Occasionally, I eat something on impulse even though I'm really not hungry.
2 ☐ I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need the food.
3 ☐ Even though I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth. Sometimes when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain weight.

I feel…
0 ☐ I don't feel any guilt or self-hate after I overeat.
1 ☐ After I overeat, occasionally I feel guilt or self-hate.
3 ☐ Almost all the time I experience strong guilt or self-hate after I overeat.

I feel…
0 ☐ I don't lose control of my eating when dieting even after periods when I overeat.
2 ☐ Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more.
3 ☐ Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When this happens I eat even more.
3 ☐ I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."

I feel…
0 ☐ I rarely eat so much food that I feel uncomfortably stuffed afterwards
1 ☐ Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed.
2 ☐ I have regular occurrences during the month when I eat large amounts of food, either at mealtime or at snacks.
3 ☐ I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit nauseous.

I feel…
0 ☐ My level of caloric intake does not go up very high or go down very low on a regular basis.
1 ☐ Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate for excess calories I've eaten.
2 ☐ I have a regular habit of overeating during the night. It seems my routine is not to be hungry in the morning, but I overeat in the evening.
3 ☐ In my adult years, I have had week-long episodes where I practically starve myself. This follows episodes of overeating. It seems I live a life of either "feast" or "famine."

I feel…
0 ☐ I am usually able to stop eating when I want to. I know when "enough is enough."
1 ☐ Every so often, I experience a compulsion to eat which I can't seem to control.
2 ☐ Frequently, I experience strong urges to eat which I seem unable to control, but at other times I can control my eating urges.
3 ☐ I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating voluntarily.

Check ONLY ONE statement under each question that best describes the way you feel on a typical day.

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I feel…
0 ☐ I don't have any problem stopping eating when I feel full.
1 ☐ I usually can stop eating when I feel full but occasionally overeat leaving me feeling uncomfortably stuffed.
2 ☐ I have a problem to stop eating once I start and usually I feel uncomfortably stuffed after I eat a meal.
3 ☐ Because I have a problem not being able to stop eating when I want, I sometimes have to induce vomiting to relieve my stuffed feeling.

I feel…
0 ☐ I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself.
1 ☐ Sometimes, when I'm with other persons, I don't eat as much as I want to eat because I'm self-conscious about my eating.
2 ☐ Frequently, I eat only a small amount of food when others are present, because I am very embarrassed about my eating.
3 ☐ I feel so ashamed about overeating that I pick times to overeat when I know no one will see me. I feel like a "closet eater."

I feel…
0 ☐ I eat three meals a day with only an occasional between meal snack.
0 ☐ I eat three meals a day, but I also normally snack between meals.
2 ☐ When I am snacking heavily, I get in the habit of skipping regular meals.
3 ☐ There are regular periods when I seem to be continually eating, with no planned meals.

I feel…
0 ☐ I don't think much about trying to control unwanted eating urges.
1 ☐ At least some of the time, I feel my thoughts are pre-occupied with trying to control my eating urges.
2 ☐ I feel that frequently I spend more time thinking about how much I ate or about trying not to eat anymore.
3 ☐ It seems to me that most of my waking hours are pre-occupied by thoughts about eating or not eating. I feel like I'm constantly struggling not to eat.

I feel…
0 ☐ I don't think about food a great deal.
1 ☐ I have strong cravings for food but they only last for brief periods of time.
2 ☐ I have days when I can't seem to think about anything else but food.
3 ☐ Most days seem to be preoccupied with thoughts about food. I feel like I live to eat.

I feel…
0 ☐ I usually know whether or not I'm physically hungry. I take the right portion of food to satisfy me.
1 ☐ Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times it's hard to know how much food I should take to satisfy me.
2 ☐ Even though I might know how many calories I should eat, I don't' have any idea what is a "normal" amount of food for me.

Gormally J, Black S, Datson S, Rardin D. The assessment of binge eating severity among obese persons. Addictive Behaviors. 1982:7;47-55