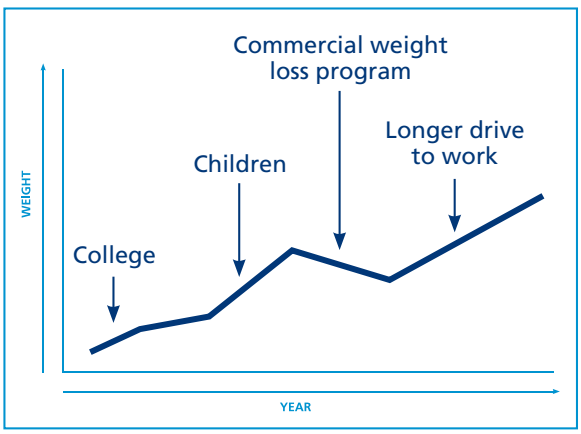
PATIENT MATERIAL

Chart Your Personal Weight History

People gain weight differently over time. Please chart your history with weight changes and the events that were related to those changes.

Example:



WEIGHT

YEAR

Name_____DOB_____

Program	Check if done	Approximate Date or Age
Weight Watchers		
Jenny Craig		
Hospital Based Program If yes, which one(s)		
Clinic Based Program If yes, which one(s)		
Meal Replacement-such as Ideal Protein, HMR, Robard If yes, which one(s)		
Home programs-such as Atkins Diet, South Beach, TOPPS, etc		

EPWORTH SLEEPINESS SCALE:

--How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze **2 = moderate chance of dozing**

1 = slight chance of dozing **3 = high chance of dozing**

ACTIVITY	**YOUR SCORE (0-3)**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (such as theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon (when able to)	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	