

**LOSS OF WEIGHT
QUESTIONNAIRE**
Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. When did you first notice that you were losing weight? _____

2. Was the weight loss intentional and under the supervision of your physician? _____
3. Who is your physician? _____

4. What is your weight currently? _____
5. Have you had any studies completed due to your weight loss? _____

6. Are you on any medication due to your weight loss? _____

7. Have you had any episodes of purging your food (vomiting after meals)? _____

8. Have you ever used laxatives to excess? _____

9. Have you ever been told that you are bulimic or anorexic? _____

10. Have you ever experienced depression or anxiety with your weight loss? _____

11. Have you ever been hospitalized for weight loss? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo