



# WatchWT™ MedGem® Analyzer Patient Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_ Gender:  Male  Female

If you are a female, please indicate if you are:  Pregnant  Lactating  Neither

Occupation: \_\_\_\_\_ Work hours per week: \_\_\_\_\_

Sleep duration (average amount of sleep per night): weekdays: \_\_\_\_\_ weekends: \_\_\_\_\_

Do you perform any exercise or purposeful physical activities?  YES  NO

If yes list the activity \_\_\_\_\_

How many hours and minutes per week? Hours \_\_\_\_\_ Minutes: \_\_\_\_\_

On a scale of 0 (no exertion at all) to 10 (very hard) please rate your feelings of exertion when you do exercise. Your feeling should reflect your total amount of exertion and fatigue, combining all sensations physical stress, effort and fatigue. Please circle the number that best represents your activity level.

0	1	2	3	4	5	6	7	8	9	10
Nothing		Very Light		Light		Moderate		Hard		Very Hard

Desired Weight Goal: \_\_\_\_\_ LBS Desired Weight Goal Date: \_\_\_\_\_

*Please check yes or no to the following questions:*

Have you had any food within the past four (4) hours?  YES  NO

Have you had any caffeine within the past four (4) hours?  YES  NO

Have you had any tobacco products within the past hour?  YES  NO

Have you performed strenuous exercise within the past four (4) hours?  YES  NO

### To be completed by clinic staff

Height: \_\_\_\_\_ Ft \_\_\_\_\_ In Weight: \_\_\_\_\_ LBS Frame Size: S:  M  L

MedGem Measurement: \_\_\_\_\_ Kcals/day \_\_\_\_\_ V02 ml/min Time of measurement: \_\_\_\_\_