Patient Health History Questionnaire

The information requested in this questionnaire is very important in order to give you the best care, and to obtain your insurance approval. Please be thorough and answer questions completely.
Blue or black ink only, please.

Name:			Date of Birth
Age:	Gender: male female	Occupation: (If retired, what did you do?)	
Height:	Weight:	Phone number:	

Primary Care Physician:

Primary Pharmacy:

WEIGHT HISTORY

What has been your heaviest weight?__________lbs.

What is the least you have ever weighed as an adult? __________lbs When? __________

In your own words, please describe what you hope to accomplish, and how you believe your life will be changed by losing weight: ____
____
____
____

Who will support you during and after your surgical weight loss procedure? ___________________________________
____

DIETARY HISTORY

Approximate age you first seriously started dieting: __________

Please identify the diets and diet programs you have tried, if any:						
Program	**Yes**	**No**	**Dates**	**Duration**	**MD supervised**	**Max Loss**
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Atkins Diet						
O.A.						
Metabolife						
Self Created Diet						
Other						

Eating Habits: ___ Sweets ___ Salty snacks ___ Portion Control ___ Skipping meals

MEDICAL HISTORY

Medical Condition	Current	Past	Medical Condition	Current	Past
AIDS			Hemorrhoids		
Alcohol Abuse			Hepatitis A		
Allergies (Seasonal)			Hepatitis B		
Angina			Hepatitis C		
Anxiety			Hernia		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Back Pain			High Triglycerides		
Bleeding Abnormality			Incontinence		
Blood Clots			Infertility		
Bronchitis			Irreguar Menses/Periods		
Cancer			Irritable Bowel Syndrome		
Chronic Cough			Kidney Disease		
Colitis			Kidney Stones		
Crohn's Disease			Liver Diease		
Deep Vein Thrombosis			Lung Disease		
Depression			Mental Illness		
Diabetes I			MI/Heart Attack		
Diabetes II			Neuropathy		
Diverticulitis			Plantar Fasciitis		
Emphysema			Polycystic Ovarian Syndrome		
Endometriosis			Pulmonary Embolus		
Epilepsy			Rheumatic Fever		
Fatty Liver			Shortness of breath		
Gallbladder Disease			Sleep Apnea		
Gestational Diabetes			Stomach Ulcer		
Gout			Stroke		
Heart Disease			Thyroid Problems		
Heart Palpitations			Venous Stasis Disease		
Heart Murmur					

SURGICAL HISTORY

Type of Surgery	Date of Surgery
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

FAMILY HISTORY

Additional Family History: (check the ones that apply)

Disease/Problem	**Relationship to patient**
___ Obesity	___
___ Diabetes	___
___ High Blood Pressure	___
___ Heart Disease	___
___ High Cholesterol	___
___ Stroke	___
___ Gallbladder Problems	___
___ Polycystic Ovary Syndrome	___
___ Lung disease, Asthma, Emphysema	___
___ Kidney Disease	___
___ Bleeding tendency/Blood Disorder	___
___ Breast Cancer	___
___ Colon Cancer	___
___ Liver Disease	___
___ Thyroid Disease	___
___ Stomach Cancer	___
___ Esophageal Cancer	___
___ Pancreatic Cancer	___

SOCIAL HISTORY

Marital Status: ___ Single ___ Engaged ___ Married ___ Partner ___ Separated ___ Divorced ___ Widowed/Widower

Do you use tobacco?

___ Never Smoked

___ Current Smoker — If yes, are you willing to quit? ___Yes ___No

Age Started ________

Packs/day _________

___ Former Smoker

Year Quit: __________

Packs/day: _________

Smokeless Tobacco ___Yes If yes, what product: ___________________________

___No When did you start: ___________________________

Do you use alcohol? ___Yes ___No

If yes, how often: ____

Type of alcohol: ____

Do you currently use recreational drugs? ___Yes ___No

If no, have you ever used recreational drugs? ___Yes ___No

Have you ever been treated for narcotic dependency? ___Yes ___No

REVIEW OF SYSTEMS

Please check all symptoms you are currently experiencing, or have experienced in the past year.

HEAD, EYE, EAR, NOSE & THROAT:

___nasal discharge
___hay fever
___sinus trouble
___earache
___headache
___blurry vision
___double vision
___vision halos
___loss of night vision
___ringing in ears
___discharge from ears
___loss of hearing
___dizziness
___vertigo
___loss of balance
___sore throat
___lump in throat
___trouble swallowing
___pain with swallowing
___hoarseness
___NONE OF THE ABOVE

RESPIRATORY:

___asthma or wheezing
___emphysema
___bronchitis
___chronic or frequent cough
___spitting/coughing up blood
___use of two pillows
___out of breath with exertion
___shortness of breath
___wake up at night short of breath
___NONE OF THE ABOVE

CARDIOVASCULAR:

___palpitations
___pounding heart
___skipping heartbeat
___chest pain
___history of heart attack
___abnormal EKG/ECG
___high blood pressure
___pain in legs
___NONE OF THE ABOVE

GASTROINTESTINAL:

___heartburn
___nausea
___vomiting
___choking on food
___food sticking in chest
___burning in stomach
___diarrhea
___constipation
___pain with bowel movement
___blood in stools
___hemorrhoids
___fissures
___gassiness
___frequent bowel movements
___NONE OF THE ABOVE

GENITOURINARY:

___pain with urination
___changes in urinary habits
___small urine stream
___blood in urine
___kidney stones
___bladder stones
___kidney failure
___nephritis
___urinary tract infection
___frequent urination
___getting up at night to urinate
___NONE OF THE ABOVE

ENDOCRINE:

___hypothyroid
___hyperthyroid
___goiter
___diabetes
___adrenal gland tumor
___frequent flushing
___frequent heavy sweating
___NONE OF THE ABOVE

MUSCULOSKELETAL:

___pain in joints
___swelling of joints
___broken bones
___sprains
___herniated disc
___limited joint motion
___NONE OF THE ABOVE

NEUROLOGICAL:

___numbness
___tingling
___weakness of any muscles
___twitching of muscles
___fainting
___convulsions
___NONE OF THE ABOVE

PSYCHOLOGICAL:

___nervousness
___anxiety
___depression
___thoughts of suicide
___suicide attempts
___hospitalization for emotional problem
___psychiatric treatment
___psychological counseling
___memory problems
___mood changes
___NONE OF THE ABOVE

REPRODUCTIVE: (females)

___premenstrual mood swings
___ taking birth control
___hormone replacement therapy
___history of ovarian cyst(s)
___menopause
___abnormal pap smear
___abnormal mammogram
___NONE OF THE ABOVE

MEDICATIONS, PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL

Medication	Strength	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

MEDICATION ALLERGIES

Name of Medication	Type of Reaction
1)	
2)	
3)	
4)	
5)	

Are you allergic to Latex? ___Yes
___No

Are you allergic to Iodine? ___Yes
___No

Are you allergic to surgical tape? ___Yes
___No

Present or past history of eating disorders?
Anorexia- fear of weight gain leading to malnutrition and ususally excessive weight loss ___ Yes ___ No
Bulemia- overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise ___ Yes ___ No
Binge Eating Disorder- consuming a large quantity of food in a short period of time ___ Yes ___ No
Night Eating Disorder- eating very late at night, waking up in the middle of the night to eat. ___ Yes ___ No

If you answered YES to any of the above:
Have you been in treatment for the disorder? ___ Yes ___ No
Do you believe you still have problems with the disorder? ___ Yes ___ No

List any other diets and/or weight loss methods you've tried: ____
____
____
Who does the grocery shopping at home? ____
Who does the cooking at home? ____
How many meals do you eat per day? ____
How many meals do you eat outside the home, **per week**? ____
Do you like/prefer carbohydrates (starches and sweets) over other foods? ____________________________________

ACTIVITY/EXERCISE

To what extent do you enjoy activity/exercise? (circle one) Not at all Slightly Moderately Greatly

Area/Methods Utilized: (check the ones that apply)

___ Health Club ___ Home ___ Outdoors ___ Pool ___ Walking ___ Jogging
___ Other: ____

Current method of exercise: (check the ones that apply)

___ No current method of exercise

___ Resistance/Weight Training
Duration per day: ______________

___ Aerobic/Endurance/Cardio Training
Frequency per week: ________________

SLEEP HISTORY

Have you been diagnosed with sleep apnea syndrome?

___Yes
___No

If yes, year diagnosed: ____________________________
Date of last sleep study? __________________________
Do you use a CPAP? ______________________________
If yes, what is your CPAP setting? _________________

Do you have or have you ever had: (check the ones that apply)

___morning headaches ___awakening at night
___restless sleep ___ trouble sleeping

OFFICE USE ONLY	Yes	No
1. Snoring		
2. Tired		
3. Observed Apnea		
4. HTN/Tx		
5. BMI/35		
6. Age/50		
7. Neck Circum. 16"		
8. Gender/Male		

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ___Yes ___No

Do you often feel tired, fatigued, or sleepy during the day? ___Yes ___No

Has anyone observed you stop breathing during your sleep? ___Yes ___No

The above information is true and correct to the best of my knowledge. I understand that the accuracy of the information provided is important, and may affect my medical outcome.

____ _____________________________
Printed name Date

____
Signature