

PATIENT HEALTH HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. ***Please be thorough.*** Blue or black ink only, please.

Name		Date	
Age	Gender Male Female	Occupation (If retired, what did you do?)	
Actual Body Weight	Your Measurements	Nurse Consult Measurement	Pre-Operative Measurement
Height			
Ideal Body Weight			
Excess Body Weight			
Target Weight			
Body Frame <i>Small</i> <i>Medium</i> <i>Large</i>		BMI	BMI
		Waist	Waist
		Hips	Hips

WEIGHT HISTORY

(Please estimate as closely as possible for all that applies.)

Life Event	Age	Weight
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

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

Name	Date
------	------

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Yes	No	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Lindora						
T.O.P.S.						
O. A.						
Metabolife						
Atkins Diet						
Pritikin Diet						
Other:						

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

	Year	Weight at Start	Weight at Delivery
Pregnancy #1			
Pregnancy #2			
Pregnancy #3			
Pregnancy #4			

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet.)

Rank each selection from ***1-like very much to 4-don't care.***

_____ Soda/Soft Drinks	_____ French Fries	_____ Chips/Snacks	_____ Fried Foods
_____ Steaks/Chops	_____ Candy	_____ Potatoes	
_____ Chocolate	_____ Pasta	_____ Cookies	
_____ Pizza	_____ Cakes/Pies	_____ Salad Dressings	

Name	Date
------	------

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease? Yes No
 If Yes: - Year Diagnosed _____
 Do you have, or have you had:

<input type="checkbox"/> Angina	<input type="checkbox"/> M.I. (myocardial infarction)
<input type="checkbox"/> CABG (coronary artery bypass graft)	<input type="checkbox"/> Abnormal EKG
<input type="checkbox"/> Stress test to rule out cardiac problems	<input type="checkbox"/> Palpitations

2. High Cholesterol? Yes No High Triglycerides? Yes No
 If Yes: - Year Diagnosed _____
 - List medications: _____

3. High Blood Pressure? Yes No
 If Yes: - Year Diagnosed _____
 - List medications _____

4. Diabetes? Yes No
 If Yes: - Year Diagnosed _____

- Gestational?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Neuropathy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Controlled with:	<input type="checkbox"/> Diet	<input type="checkbox"/> Oral Medication (list)	_____
- Last fasting blood sugar	_____		

5. Asthma? Yes No
 If Yes: - Year Diagnosed _____
 - ER visits/last 2 yrs. _____
 - Hospitalizations last 2 yrs. _____
 - Steroids last 2 yrs.? Yes No

6. Shortness of breath? Yes No
 If Yes: - Can walk _____ Blocks _____
 - Stairs _____ Flights _____

7. Trouble Sleeping? Yes No

- Morning headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Restless sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Awakenings at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Daytime drowsiness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Snoring?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
- Observed apneas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Office Use: Sleep study ordered Initials _____

Name	Date
------	------

8. Sleep Apnea Syndrome? Yes No
 If Yes: - Year Diagnosed _____
 - Last sleep study? _____ Month/Year
 - CPAP used? Yes No

9. Heartburn/esophagitis/hiatus hernia? Yes No
 If Yes: - Year Diagnosed _____
 - Upper GI series? Yes No
 - Endoscopy? Yes No
 - Medications: _____
 - Frequency of use: _____

10. Belching up acid or sour fluid? Yes No

11. Coughing or choking at night? Yes No

12. Gallbladder disease? Yes No
 If Yes: - How was it diagnosed? Ultrasound Physical exam

13. Leakage of urine with laughing/coughing/sneezing? Yes No
 If Yes: - Wear pads frequently? Yes No

14. Low back strain/Pain/Sciatica? Yes No
 If Yes: - Seen by Chiropractor? Yes No
 - Orthopedic Surgeon? Yes No
 - Seen by Family Doctor? Yes No
 - Medications taken: _____

15. Pain in Hips/Knees/Ankles/Feet? Yes No
 If Yes: - Seen by Chiropractor? Yes No
 - Orthopedic Surgeon? Yes No
 - Seen by Family Doctor? Yes No
 - Medications taken: _____

16. Weight related injuries and trauma: _____

17. Venous Stasis Disease? Yes No
 If Yes: - Do you have Edema? Yes No
 - Scaly & Thick Skin? Yes No
 - Leg Ulcers? Yes No

18. Gout? Yes No
 If Yes: - Gouty Arthritis? Yes No
 - Medications taken: _____

OK BARIATRICS.COM

Name	Date
------	------

19. History of deep vein thrombosis (DVT), blood clots or pulmonary embolus? _____ Yes _____ No
 Family history? _____ Yes _____ No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

_____ Measles	_____ Mumps	_____ Chickenpox	_____ Obesity
_____ Rheumatic fever	_____ Heart murmur	_____ Asthma	_____ Tonsillectomy

Female Patients:

Number of pregnancies: _____	Age at first period: _____
Number of live births: _____	Date of last period: _____
Miscarriages/abortions: _____	
Obstetric complications: _____	

Do you presently use:

Birth control pills? _____ Yes _____ No	List type: _____
Estrogens? _____ Yes _____ No	List type: _____
Other Contraceptive method: _____	

Serious Illnesses:

Have you had:

_____ Hepatitis	_____ Blood Transfusion	_____ AIDS/HIV Exposure
_____ Colitis	_____ Kidney Disease	_____ Bleeding Abnormality
_____ Thyroid Problems:	_____	
_____ NONE OF THE ABOVE	_____	

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness	Date	Treatment

Major Surgery	Date

OK BARIATRICS.COM

Name	Date
------	------

Allergies:

Allergic to any medications? Yes No If Yes, please list medication and reaction:

Allergic to: Surgical tape? Yes No Other Allergies:

Latex? Yes No

Iodine? Yes No

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco? Yes No Frequency:

Are you willing to quit? Yes No

Have you ever used tobacco? Yes No Frequency:

When did you quit?

Do you use alcohol? Yes No Frequency:

Have you ever been treated for narcotic dependency? Yes No

Do you currently utilize recreational drugs? Yes No

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

OK BARIATRICS.COM

Name	Date
------	------

Please indicate if there is a family history of:

<input type="checkbox"/> Obesity	<input type="checkbox"/> Lung disease, Asthma or Emphysema
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding tendency or Blood Disorder (blood clot, DVT or emboli)
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> High Blood Cholesterol	<input type="checkbox"/> Colon Cancer

Personal Physicians:

Please list all of the physicians under whom you receive medical care:

	Name	Address/Location	Phone Number	Fax Number
Primary Care Physician		Must be completed	Must be completed	Must be completed
Cardiologist				
Pulmonologist				
Other				

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness – **NONE OF THE ABOVE.**
2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis – **NONE OF THE ABOVE.**

Name	Date
------	------

3. **CARDIOVASCULAR:** palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses – *NONE OF THE ABOVE.*
4. **GASTROINTESTINAL:** heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis – *NONE OF THE ABOVE.*
5. **GENITOURINARY:** pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze – *NONE OF THE ABOVE.*
6. **ENDOCRINE (GLANDULAR):** low thyroid – hyperthyroid – goiter – Grave’s Disease – thyroid nodules – x-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating – *NONE OF THE ABOVE.*
7. **MUSCULOSKELETAL:** pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica – *NONE OF THE ABOVE.*
8. **NEUROLOGICAL:** dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness – *NONE OF THE ABOVE.*
9. **PSYCHOLOGICAL:** nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling – *NONE OF THE ABOVE.*

The above information is true and correct to the best of my belief. I understand that the accuracy of this information is important and may affect medical outcomes.

Patient Name

Date