

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		
Height		
Referral Source		

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:

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						
Atkins Diet						

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Name	Date
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Program	Yes	No	Dates	Duration	MD Supervised?	Max Loss
O. A.						
Metabolife						

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

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

DIETARY / EATING PATTERNS:

Who does the shopping at home? _____

Who does the cooking at home? _____

How many meals do you eat per day? _____

How many meals do you eat **per week** outside of the home? _____

Do you like carbohydrates (starches and sweets) more than other foods? _____

ACTIVITY / EXERCISE:

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

Area/Methods Utilized: Health Club Home Outdoors Pool Walking Jogging
Sports: _____

Method of Exercise:

Aerobic/Endurance Training: Y / N

Resistance Training: Y / N

Frequency per week: _____

Duration per day: _____

Activity/Exercise in the past: Y / N What kinds of activity: _____

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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

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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: _____

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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 you have experienced:

<input type="checkbox"/> Stroke	<input type="checkbox"/> Obesity	<input type="checkbox"/> Infertility	<input type="checkbox"/> Polycystic Ovary Syndrome
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> AIDS/HIV Exposure
<input type="checkbox"/> Colitis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Bleeding Abnormality

Female Patients:

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

Do you presently use:

Birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No	List type: _____
Estrogens? <input type="checkbox"/> Yes <input type="checkbox"/> No	List type: _____
Other Contraceptive method: _____	

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

Surgery History	Date

Allergies:

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

Allergic to: Surgical tape? <input type="checkbox"/> Yes <input type="checkbox"/> No Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Allergies: _____ _____
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Name	Date
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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 |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Polycystic ovary Syndrome | |

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	<i>Must be completed</i>	<i>Must be completed</i>
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*.

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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 – recent change in bowel habits – *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 – frequent urinary tract infections – genital lesions – unusual discharge - *NONE OF THE ABOVE.*
6. **ENDOCRINE (GLANDULAR):** low thyroid – hyperthyroid – goiter – Graves’ 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 – limited joint motion – *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 – memory problems – mood changes – *NONE OF THE ABOVE.*
10. **REPRODUCTIVE (Females):** premenstrual mood swings – inability to conceive –hormone replacement therapy – history of ovarian cysts – menopause – regular Pap smears – abnormal Pap smears –abnormal mammogram – *NONE OF THE ABOVE.*

How would you describe your general mood and emotions?

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Present or past history of eating disorders?

- Yes No Anorexia (fear of weight gain leading to malnutrition and usually excessive weight loss)
- Yes No Bulimia (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)

If you have answered YES to any of the above:

- Yes No Have you been in treatment for the disorder?
- Yes No Do you believe you still have problems with the disorder?

What type of medication or treatment plans have you completed related to eating disorders?

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