

Patient Questionnaire

First name _____ Last name _____

Address _____

City _____ State _____ Zip _____

Telephone () _____ Social Security # _____ - _____ - _____

DOB ____/____/____ Marital Status _____ Children _____

A. Medical History: Do you have or have you had any of the following?

1. Diabetes **Yes** **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

2. High Blood Pressure **Yes** **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

3. Heart Disease **Yes** **No**

Check if you have any of the following

Chest pain
Angina
Coronary Artery Disease
Congestive Heart Failure
Heart Attack

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

4. Stroke **Yes** **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

5. High Cholesterol

Yes

No

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

6. Arthritis

Yes

No

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

7. Muscle and Joint pain

Yes

No

Check if you have any of the following

Hip pain

Knee pain

Foot and Ankle pain

Leg and Foot swelling

Back pain

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

8. Sleep problems

Yes

No

Check if you have any of the following

Sleep apnea

Snoring

Early fatigue

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

9. Breathing problems

Yes **No**

Check if you have any of the following

Asthma
Shortness of Breath
Difficulty in Breathing
Snoring
Other _____

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

10. Gastro-esophageal reflux

Yes **No**

Check if you have any of the following

Heartburn
Difficulty swallowing
Other _____

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

11. Depression

Yes **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

12. Cancer

Yes **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

13. Venous insufficiency (i.e. varicose veins)

Yes **No**

If yes: Duration of problem _____

Form of treatment (List medication and doses) _____

B. Do you take any medications

Yes

No

<i>Medicine</i>	<i>Duration taking Medicine</i>	<i>Dose</i>

C. Do you have any allergies ?

Yes

No

<i>Drugs</i>	<i>Reaction</i>

<i>Other</i>	<i>Reaction</i>

D. Have you had any previous surgery?

Yes

No

If yes please list them starting with the most recent

<i>Year</i>	<i>Hospital</i>	<i>Operation</i>	<i>Complications</i>

Did you have General Anesthesia?

Yes

No

If yes: Did you experience any problem? _____

E. Family Medical History

Family History

Obesity	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Other _____		

If yes , please fill in the details for the family member with the medical problem and specify. Also, please specify cause of death if family member is deceased.

<i>Mother</i>	<i>Father</i>
<i>Maternal Grandfather</i>	<i>Paternal Granfather</i>
<i>Maternal Grandmother</i>	<i>Paternal Grandmother</i>
<i>Brother</i>	<i>Sister</i>
<i>Cousins (maternal)</i>	<i>Cousins (Paternal)</i>
<i>Uncle and Aunts (maternal)</i>	<i>Uncle and Aunts (Paternal)</i>

F. Previous attempts at losing weight

Insurance companies request the period of time you have been engaged in attempts to lose weight and professionals you may have consulted? So, Please answer the following as completely as possible.

Have you participated in a commercial weight loss program ? Yes No

If yes, please provide details

<i>Program</i>	<i>Dates attended</i>	<i>Total weight Loss</i>	<i>Duration of loss</i>
<i>Weight Watchers</i>			
<i>Richard Simmons</i>			
<i>Physicians Weight Loss</i>			
<i>Slimfast</i>			
<i>Jenny Craig</i>			
<i>Susan Pouter</i>			
<i>Health Spas</i>			
<i>Gym/Exercise Program</i>			
<i>Others(i.e. Books and tapes)</i>			

Have you been involved in medically or professionally supervised programs? Yes No

If yes, please list

<i>Doctor/Nutritionist</i>	<i>Duration</i>	<i>Outcome</i>

Have you been prescribed any weight loss medications (i.e. Phen-fen) ? Yes No

If yes, please list

<i>Medication</i>	<i>Duration of use</i>	<i>Weight loss</i>	<i>Duration of loss</i>	<i>Reason stop Med.</i>

Last 24 hour intake or Typical Day

Breakfast:
Lunch:
Dinner:
Morning Snacks:
Afternoon Snacks:
Evening Snacks:
Middle of the night Snacks:
Alcohol
Sweets
Pizza/Fast foods
Eating Binges

G. Weight History

Since when have you been overweight ? _____

What was your lowest weight as an adult ? _____

What was your highest weight as an adult ? _____

What was your biggest weight loss (lbs) and how long did it take you? _____

How long did it take you to regain the weight? _____

How much did you weigh at age 18? _____

H. Current Weight

<i>Height</i>	<i>Weight</i>	<i>Comments</i>
_____ feet _____ in	_____ lbs	

<i>Most of the weight is around:</i>	<i>%</i>	<i>Comments</i>
<i>Chest</i>		
<i>Abdomen</i>		
<i>Buttocks</i>		
<i>Thigh</i>		
<i>Evenly Distributed</i>		

I. Mini Psychiatric Assessment

Have you had psychological or psychiatric counseling for weight loss or problems associated with weight loss? Yes No

If yes, please list

<i>Name of counselor</i>	<i>Address</i>	<i>When</i>

Please circle the following scale numbering the limitation which excess weight has on the following components of your life (1= minimal effect, 5= severely affects quality of life

<i>Physical activity</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Self esteem</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Social Involvement</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Ability to work</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Particioation in recreational activities</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Interest in sex</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Financial well-being</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

How else has extra weight limited your quality of life? _____

How much weight loss are you expecting after surgery? _____ lbs

What other benefits do you expect surgery to provide? _____

J. Insurance Information

Name of Insurance provider _____

Address of Insurance provider _____

_____ *Phone* () _____

Membership ID # _____ *Group #* _____

If you are insured under another person's coverage , please list that person

Name _____ *SS#* _____ - _____ - _____

Relationship _____ *Ins ID* _____

Primary Care Physician

Name _____ *Phone* () _____

Address _____

Please provide list of Physicians who can provide letters of support of surgical procedure to your insurance company

Name _____ *Phone* () _____

Address _____

Name _____ *Phone* () _____

Address _____

Name _____ *Phone* () _____

Address _____
