

## PATIENT HISTORY QUESTIONNAIRE

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

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

**Patient Name:** \_\_\_\_\_

**In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:** \_\_\_\_\_

## DIETARY HISTORY

Approximate age when you first seriously dieted: \_\_\_\_\_

**List the diets and diet programs you have tried:**

<b>Program</b>	<b>Yes</b>	<b>No</b>	<b>Dates</b>	<b>Duration</b>	<b>MD Supervised?</b>	<b>Max Loss</b>
Jenny Craig:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
OptiFast	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Meridia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Lindora	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
O.A.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Metabolife	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____	_____

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:**

Pregnancy #1 Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #2 Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #3 Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

Pregnancy #4 Year \_\_\_\_\_ Weight at start \_\_\_\_\_ at delivery \_\_\_\_\_

## 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

**Patient Name:** \_\_\_\_\_

Steaks/chops                       Candy                       Potatoes  
 Chocolate                       Pasta                       Cookies  
 Pizza                       Cakes/pies                       Salad dressings  
 Fried foods

## 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:**

Angina

M.I. (myocardial infarction)

CABG (coronary artery bypass graft)

Abnormal EKG

Stress test to rule out cardiac problems

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:                       Yes     No

Neuropathy:                       Yes     No

Controlled with:  Diet

Oral Medication (list) \_\_\_\_\_

Last fasting blood sugar: \_\_\_\_\_

5. Asthma                       Yes     No

If Yes:  Year Diagnosed: \_\_\_\_\_

ER visits/last 2 yrs: \_\_\_\_\_

Hospitalizations last 2 years: \_\_\_\_\_

Steroids last 2 years:                       Yes     No

Patient Name: \_\_\_\_\_

6. Shortness of breath ↑ Yes ↑ No

If Yes, :  Can walk \_\_\_\_\_ blocks

Stairs: \_\_\_\_\_ flights

7. Trouble Sleeping? ↑ Yes ↑ No

Morning headaches ↑ Yes ↑ No

Daytime drowsiness ↑ Yes ↑ No

Restless sleep ↑ Yes ↑ No

Snoring ↑ Yes ↑ No

Awakenings at night ↑ Yes ↑ No

Observed apneas ↑ Yes ↑ No

Office Use: ↑ sleep study ordered \_\_\_\_\_ initials

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

Office Use:  UGI/endoscopy

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

15. 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: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

16. 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 \_\_\_\_\_

17. Weight related injuries and trauma: \_\_\_\_\_

18. Venous Stasis Disease?  Yes  No

If Yes:  Do you have Edema?  Yes  No

Scaly & Thick Skin?  Yes  No

Leg Ulcers?  Yes  No

19. Gout?  Yes  No

If Yes:  Gouty Arthritis?  Yes  No

Using Medication? \_\_\_\_\_

Have you ever taken Allopurinol?  Yes  No When? \_\_\_\_\_

20. Bra size (females only): \_\_\_\_\_

Skin depressions from bra straps?  Yes  No

Do you have shoulder pain?  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: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## SERIOUS ILLNESSES

**Have you had:**

Hepatitis

Blood Transfusion

AIDS/HIV Exposure

Colitis

Kidney Disease

Bleeding Abnormality

Thyroid Problems \_\_\_\_\_

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

Major Illness

Date

Treatment

Major Illness	Date	Treatment

Major Surgery

Date

Major Surgery	Date

Allergic to any medications?

Yes

No

If Yes, please list medication and reaction:


Allergic to: **Surgical tape:**  Yes

No

**Latex:**  Yes

No

**Iodine:**  Yes

No

Other Allergies:

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### 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

Do you use alcohol:

Yes

No

Frequency:

\_\_\_\_\_

*Patient Name:* \_\_\_\_\_

## FAMILY HISTORY

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

*Please indicate if there is a family history of:*

- |                          |                                       |
|--------------------------|---------------------------------------|
| ↑ Obesity                | ↑ Lung disease, Asthma or Emphysema   |
| ↑ Diabetes               | ↑ Kidney Disease                      |
| ↑ High Blood Pressure    | ↑ Bleeding tendency or Blood Disorder |
| ↑ Heart Disease          | ↑ Breast Cancer                       |
| ↑ High Blood Cholesterol | ↑ Colon Cancer                        |

## PERSONAL PHYSICIANS

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

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Other	_____	_____	_____

Patient Name: \_\_\_\_\_

## **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

**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

**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

**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

**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

Men: Discharge from penis – loss of erection – painful erection

Women: Vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

**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

**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

**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

**PSYCHOLOGICAL:** nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

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**(Patient Signature/ Date)**

The above is true and correct to the best of my belief