PATIENT HISTORY

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. If you are visually or otherwise impaired and must use an assistant, please indicate his/her name below.

Date_____

Last Name_____ First Name_____ Date of Birth_____

Age_____ Height_____ Weight_____

Approximately how long have you currently been at least 80-100 pounds overweight?

_____Years _____Months

DIET HISTORY

Approximate age when you first dieted_____

Programs	Dates	Duration	MD Supervised?		Maximum Loss
☐ Jenny Craig			☐ Yes	☐ No	
☐ Nutri-Systems			☐ Yes	☐ No	
☐ Weight Watchers			☐ Yes	☐ No	
☐ OptiFast			☐ Yes	☐ No	
☐ MediFast			☐ Yes	☐ No	
☐ Fen/Phen/Redux			☐ Yes	☐ No	
☐ Meridia			☐ Yes	☐ No	
☐ Lindora			☐ Yes	☐ No	
☐ T.O.P.S.			☐ Yes	☐ No	
☐ O.A.			☐ Yes	☐ No	
☐ Metabolife			☐ Yes	☐ No	
☐ Atkins			☐ Yes	☐ No	
☐ Pritikin			☐ Yes	☐ No	
☐ Hypnosis			☐ Yes	☐ No	
☐ Acupuncture			☐ Yes	☐ No	

Your Name _____

List any other weight loss attempt(s) your physician supervised and documented

_____

List any others diets and/or weight loss methods you've tried

_____

_____

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

_____

_____

MEDICATIONS

List all medications you are currently taking with the dosages and strengths. Also include any over- the-counter medications, herbal and dietary supplements you take.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Do you currently take:

Goody Powders ☐ Yes ☐ No If "Yes", how often _____

Aspirin ☐ Yes ☐ No If "Yes", how often _____

NSAIDs (*Motrin, Aleve, etc.*) ☐ Yes ☐ No If "Yes", how often _____

Other aspirin-based products ☐ Yes ☐ No If "Yes", how often _____ Which ones _____

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Your Name _____

MEDICAL CONDITIONS/DISEASES

Have you had or do you have any of the following illnesses or conditions? If so, please briefly explain treatment you received.

Heart Disease

☐ Angina Treatment _____
☐ Heart Attack (MI) Date _____
☐ Coronary Artery Bypass(CABG) Date _____ Hospital _____
☐ Coronary Angioplasty or Stents Date _____ Hospital _____
☐ Abnormal EKG Treatment _____
☐ Abnormal Stress Test Date _____ Where was it done? _____
☐ Palpitations/heart murmur/valve problem Treatment _____
☐ Heart failure, CHF Treatment _____
Other _____

Lung/Pulmonary Disease

☐ Asthma
☐ Chronic Obstructive Pulmonary Disease Date _____ Hospital _____
☐ Sleep apnea. If checked, CPAP or BiPAP used or recommended? ☐ Yes ☐ No
If "Yes" What Setting _____ mm water
☐ Pneumonia. If checked, after surgery? ☐ Yes ☐ No
Other _____

Gastrointestinal Disease

☐ Ulcer/Bleeding Ulcer Treatment _____
☐ Acid Reflux/Gastroesphogeal Reflux Disease
☐ Irritable bowel syndrome ☐ Colitis/Diverticulitis
Other _____

Kidneys/Bladder

☐ Kidney Stones ☐ Renal Insufficiency/Failure (Chronic or Acute)
☐ Urinary Retention (particularly after surgery) ☐ Urinary Incontinence (Leakage)
Other _____

Vascular / Blood, Blood Vessels

☐ High blood pressure. If checked, is it well controlled? ☐ Yes ☐ No
☐ High Cholesterol ☐ High Triglycerides ☐ Clots in Legs (DVT)
☐ Clots in Lungs (Pulmonary Embolus) ☐ Anemia ☐ Free Bleeder/Hemophiliac
☐ Blood Transfusion ☐ Venous Stasis Disease/Ulcers
Other _____

Your Name _____

Endocrine

☐ Diabetes Mellitus Year Diagnosed_____ ☐ Oral Medication ☐ Insulin Injections
Date of Last Hemoglobin A1c_____Value_____
☐ Under-active Thyroid
Other_____

Nervous System

☐ Migraine / Headaches ☐ Neuropathy ☐ Slipped/Degenerative Disk ☐ Stroke
☐ TIAS (mini-strokes) ☐ Seizure Disorder
Other_____

Muscle/Joint/Skeletal Disease

☐ Arthritis, Area_____ ☐ Rheumatoid Arthritis ☐ Lupus (SLE) ☐ Gout ☐ Spine Disease
☐ Degenerative Joint Disease ☐ Fractures ☐ Fibromyalgia
Other_____

Infectious Disease

☐ Staph Infection ☐ Hepatitis ☐ HIV Infection ☐ Tuberculosis (TB)
Other_____

Mental Health

☐ Depression ☐ Bi-polar ☐ Panic Disorder ☐ Schizophrenia
Other_____

Allergies

Are you allergic to
☐ Tape ☐ Latex ☐ Iodine ☐ Food. If checked, what food_____
List any other drug allergies or intolerances you know of and the effect(s) they cause

_____

SURGICAL HISTORY

☐ Gallbladder Removal. If checked, was ☐ Open (Large Incision) ☐ Laparoscopic
☐ Abdominal ☐ Orthopedic/Spinal ☐ Head/Neck/Throat ☐ Chest/Breast
☐ Pelvic/Urinary Tract ☐ Plastic Surgery
Other_____

Did you have any significant complications with any of your surgeries (infection, bleeding, anesthesia reaction, breathing/lung problems)? _____

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Your Name _____

HOSPITALIZATIONS

Please list any admission(s) and the approximate dates and the reasons(s) other than the surgeries listed above

Reason_____ Date_____ Hospital _____

Reason_____ Date_____ Hospital _____

Reason_____ Date_____ Hospital _____

Reason_____ Date_____ Hospital _____

FAMILY MEDICAL HISTORY

Please list any conditions that tend to run in your family

_____

_____

Did anyone in your immediate family suffer a heart attack before the age of 50? ☐ Yes ☐ No

What is your relationship with this person? _____

SOCIAL HISTORY

Have you ever used tobacco? ☐ Yes ☐ No What type? _____

When did you quit?_____ Approximately how many total years did you use tobacco?_____

Do you use or have you ever used intravenous (IV)drugs?_____

Do you use or have you used illegal drugs? ☐ Yes ☐ No What type?_____

Who resides with you in your household?_____

Do you have any religious objections to medical treatment? ☐ Yes ☐ No If "Yes", what sort?_____

Do you drink any form of alcohol? ☐ Yes ☐ No

If "Yes", how many drinks of beer, wine or liquor have you had in the past 7 days?_____Past 30 days? _____

What is your occupation?_____

What are your hobbies, recreation, etc._____

Who is your power of attorney for medical decisions (the person you would want to make decisions regarding your healthcare in the case that you cannot)? _____

Your Name _____

REVIEW OF SYSTEMS

Please circle the symptoms or problems below that you experience on a frequent basis or have experienced in the last three to four weeks. **If you are unsure, please place a question mark beside that item.**

Constitutional

☐ Weight Gain ☐ Fatigue ☐ Loss of Appetite ☐ Weight Loss ☐ Night Sweats ☐ Fever/Chills ☐ Weakness

Skin

☐ Rash ☐ Change in Size/Color of Mole ☐ Lumps

Neurological

☐ Headache/Migraine ☐ Tingling/Numbness ☐ Seizures ☐ Insomnia ☐ Memory Loss ☐ Trouble Walking
☐ Change in Hearing or Vision ☐ Weakness on One Side

Lungs/Breathing

☐ Short of Breath at Rest ☐ Coughing Up Blood ☐ Trouble Breathing with Exertion
☐ Stop Breathing During Sleep ☐ Dizziness ☐ Wheezing ☐ Chronic Cough ☐ Snoring

Blood/Blood Vessels

☐ Easy Bruising ☐ Easy Bleeding

Bladder/Kidneys

☐ Urgent Need to Urinate ☐ Urinary Retention, Especially After Anesthesia
☐ Bladder Leaks When Sneezing/Laughing, etc. ☐ Painful Or Difficult Urination
☐ Blood In Urine ☐ Recurrent Infections Of Bladder Or Kidneys

Ears, Nose, Throat

☐ Colds ☐ Chronic Cough ☐ Nose Bleed ☐ Change in Voice ☐ Sore Throat ☐ Ringing in Ears
☐ Trouble Swallowing ☐ Dentures ☐ Loose Teeth

Heart

☐ Dizziness ☐ Chest Pain ☐ Palpitations (Rapid or Fluttering Heart Beat) ☐ Leg Swelling
☐ Loss of Consciousness ☐ Pain in Legs After Walking

Stomach/Bowels

☐ Abdominal Pain ☐ Diarrhea ☐ Acid Reflux ☐ Constipation ☐ Nausea ☐ Black, Tar-Like Stool
☐ Vomiting ☐ Vomiting Blood ☐ Difficulty Swallowing ☐ Change In Bowel Habits
☐ Pain In Abdomen After Eating ☐ Blood In Stool ☐ Heartburn

Your Name _____

REVIEW OF SYSTEMS *(Continues)*

Muscles/Joints/Bones

☐ Joint Stiffness ☐ Leg Cramps ☐ Joint Pain ☐ Joint Swelling ☐ Back Pain ☐ Balance Problems
☐ Inability To Move Extremity ☐ Muscle Pain Or Weakness

Psychiatric/Emotional

☐ High Stress
☐ Memory Loss
☐ Sleeping More/Less
☐ Sadness
☐ Thoughts Of Suicide
☐ Victim Of Mental Or Physical Abuse
☐ Use Illegal Drugs Or Alcohol To Cope With Stress
☐ Take No Pleasure In Life

Female Reproductive

☐ Heavy Or Painful Periods
☐ Infertility
☐ Irregular Periods
☐ Number Of Pregnancies # _____
☐ Number Of Live Births # _____
☐ Number Of Miscarriages # _____
☐ Complication Of Pregnancy (High Blood Pressure, Diabetes, Toxemia). Explain:

_____

Date Of Your Last Normal Period _____

Birth Control Method _____

So that we may provide you with the best possible care, is there anything else you would like us to know about your health or situation? _____

_____

_____

_____

_____

_____

_____