Patient Health History Questionnaire

Bariatric Partners of Oklahoma

The information requested in this questionnaire is very important in order to give you the best care, and to obtain your insurance approval. Please be thorough and answer questions completely.
Blue or black ink only, please.

Name:		Date of Birth
Age:	Gender: male female	Best contact phone number:

How did you hear about INTEGRIS Weight Loss Center/Dr. Le?

Referring Provider:	
Primary Care Physician:	PCP Phone Number:
Primary Pharmacy:	Pharmacy Phone Number:

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: _____
_____
_____
_____
Who will support you during and after your surgical weight loss procedure? _____
_____

DIETARY HISTORY

Approximate age you first seriously started dieting: _____

Please identify the diets and diet programs you have tried, if any:						
Program	**Yes**	**No**	**Dates**	**Duration**	**MD supervised**	**Max Loss**
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Atkins Diet						
O.A.						
Metabolife						
Self Created Diet						
Other						

Eating Habits: ___ Sweets ___ Salty snacks ___ Skipping meals ___ Portion Control

Present or past history of eating disorders?

Anorexia- fear of weight gain leading to malnutrition and ususally excessive weight loss	___ Yes	___ No
Bulemia- 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.	___ Yes	___ No

If you answered YES to any of the above:

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

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

_____

_____

Who does the grocery shopping at home? _____

Who does the cooking at home? _____

How many meals do you eat per day? _____

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

Do you like/prefer carbohydrates (starches and sweets) over other foods? _____

MEDICATIONS; PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL

Medication	Strength	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

MEDICATION ALLERGIES

Name of Medication	Type of Reaction
1)	
2)	
3)	
4)	
5)	

Are you allergic to Latex? ___Yes ___No

Are you allergic to Iodine? ___Yes ___No

Are you allergic to surgical tape? ___Yes ___No

MEDICAL HISTORY

Medical Condition	Current	Past	Medical Condition	Current	Past

AIDS			Hemorrhoids		
Alcohol Abuse			Hepatitis A		
Allergies (Seasonal)			Hepatitis B		
Angina			Hepatitis C		
Anxiety			Hernia		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Bleeding Abnormality			High Triglycerides		
Blood Clots			Incontinence		
Bronchitis			Infertility		
Cancer			Irreguar Menses/Periods		
Chronic Cough			Irritable Bowel Syndrome		
Colitis			Kidney Disease		
Crohn's Disease			Kidney Stones		
Deep Vein Thrombosis			Liver Diease		
Depression			Lower Back Bain		
Diabetes I			Lung Disease		
Diabetes II			Mental Illness		
Diverticulitis			MI/Heart Attack		
Emphysema			Neuropathy		
Endometriosis			Plantar Fasciitis		
Epilepsy			Polycystic Ovarian Syndrome		
Fatty Liver			Pulmonary Embolus		
Gallbladder Disease			Rheumatic Fever		
Gestational Diabetes			Shortness of breath		
Gout			Sleep Apnea		
Heart Disease			Stomach Ulcer		
Heart Palpitations			Stroke		
Heart Murmur			Thyroid Problems		
			Venous Stasis Disease		

SURGICAL HISTORY

Check if you have had no prior surgeries. _____

Type of Surgery	Date of Surgery
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

FAMILY HISTORY

Additional Family History: (check the ones that apply)

Disease/Problem **Relationship to patient**

___ Obesity _____

___ Diabetes _____

___ High Blood Pressure _____

___ Heart Disease
___ High Cholesterol
___ Stroke
___ Gallbladder Problems
___ Polycystic Ovary Syndrome
___ Lung disease Please explain:
___ Kidney Disease
___ Bleeding tendency/Blood Disorder
___ Breast Cancer
___ Colon Cancer
___ Liver Disease
___ Thyroid Disease
___ Stomach Cancer
___ Esophageal Cancer
___ Pancreatic Cancer

SOCIAL HISTORY

Marital Status (circle one): Single Engaged Married Partner Separated Divorced Widowed/Widower
Spouse/Partners name:
Religious Denomination:
Occupation: If retired, what did you do?

History of Tobacco use:

___ **Never Smoked**

___ **Current Smoker** Are you willing to quit? ___ Yes ___ No
Year Started: _____
Packs/day: _____

___ **Former Smoker**
Year Started: _____
Year Quit: _____
Packs/day: _____

___ **Smokeless Tobacco** ___Yes ___No If yes, what product: _____ When did you start: _____

Do you use alcohol? ___Yes ___No If yes, how often: _____ Type of alcohol: _____

Do you currently use recreational drugs? ___Yes ___No

Have you ever been treated for narcotic dependency? ___Yes ___No

REVIEW OF SYSTEMS

Please check all symptoms you are currently experiencing, or have experienced in the past year.

HEAD, EYE, EAR, NOSE & THROAT:
___nasal discharge
___hay fever
___sinus trouble
___earache

GASTROINTESTINAL:
___heartburn
___nausea
___vomiting
___choking on food

MUSCULOSKELETAL:
___pain in joints
___swelling of joints
___broken bones
___sprains

___headache
___blurry vision
___double vision
___vision halos
___difficulty seeing at night
___ringing in ears
___discharge from ears
___loss of hearing
___dizziness
___vertigo (spinning dizziness)
___difficulty with balance
___sore throat
___lump in throat
___difficulty swallowing (dysphagia)
___pain with swallowing
___hoarseness
___NONE OF THE ABOVE

RESPIRATORY:
___wheezing
___emphysema
___bronchitis
___cough
___spitting/coughing up blood
___use of two or more pillows at night
___out of breath with exertion
___shortness of breath
___wake up at night short of breath
___NONE OF THE ABOVE

CARDIOVASCULAR:
___palpitations
___pounding heartbeat
___skipping heartbeat
___chest pain or discomfort
___history of heart attack
___abnormal EKG/ECG
___high blood pressure
___pain in legs
___NONE OF THE ABOVE

___food sticking in chest
___burning in stomach
___diarrhea
___constipation
___pain with bowel movement
___blood in stools
___hemorrhoids
___fissures
___gassiness
___frequent bowel movements
___NONE OF THE ABOVE

GENITOURINARY:
___pain with urination
___changes in urinary habits
___small urine stream
___blood in urine
___kidney stones
___bladder stones
___kidney failure
___nephritis
___urinary tract infection
___frequent urination
___getting up at night to urinate
___NONE OF THE ABOVE

ENDOCRINE:
___hypothyroid
___hyperthyroid
___goiter
___diabetes
___adrenal gland tumor
___frequent flushing
___frequent heavy sweating
___NONE OF THE ABOVE

___herniated disc
___limited joint motion
___NONE OF THE ABOVE

NEUROLOGICAL:
___numbness
___tingling
___weakness of any muscles
___twitching of muscles
___fainting
___convulsions
___NONE OF THE ABOVE

PSYCHOLOGICAL:
___nervousness
___anxiety
___depression
___thoughts of suicide
___suicide attempts
___hospitalization for emotional problem
___psychiatric treatment
___psychological counseling
___memory problems
___mood changes
___NONE OF THE ABOVE

REPRODUCTIVE: (females)
___premenstrual mood swings
___ taking birth control
___hormone replacement therapy
___history of ovarian cyst(s)
___menopause
___abnormal pap smear
___abnormal mammogram
___NONE OF THE ABOVE

ACTIVITY/EXERCISE

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

Area/Methods Utilized: (check the ones that apply)

___ Health Club ___ Home ___ Outdoors ___ Pool ___ Walking ___ Jogging
___ Other: _____

Current method of exercise: (check the ones that apply) ___ No current method of exercise

___ Resistance/Weight Training
Duration per day: _____

___ Aerobic/Endurance/Cardio Training
Frequency per week: _____

SLEEP HISTORY

Have you been diagnosed with sleep apnea syndrome? ___Yes ___No

If yes, year diagnosed: _____
Date of last sleep study? _____
Do you use a CPAP? _____
If yes, what is your CPAP setting? _____

Do you have or have you ever had: (check the ones that apply)

___morning headaches ___awakening at night
___restless sleep ___ trouble sleeping

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ___Yes ___No

Do you often feel tired, fatigued, or sleepy during the day? ___Yes ___No

Has anyone observed you stop breathing during your sleep? ___Yes ___No

OFFICE USE ONLY	Yes
1. Snoring	
2. Tired	
3. Observed Apnea	
4. HTN/Tx	
5. BMI/35	
6. Age/50	
7. Neck Circum. 16"	
8. Gender/Male	

The above information is true and correct to the best of my knowledge. I understand that the accuracy of the information provided is important, and may affect my medical outcome.

_____ _____
Printed name Date

_____
Signature