

PATIENT HEALTH 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, detailed responses. Don't forget to bring this completed form with you to your first appointment. If you have any questions, please contact the Surgical Weight Loss Center at 812-523-5230.

Today's date: _____

First name: _____

Last name: _____

Gender: Female Male

Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail address: _____

Marital status: Single Married Divorced Widowed

Spouse name: _____

Do you have a belief system or religion that would interfere with receiving some or all of the recommended treatments for this program? If so, please disclose your religion: _____

Patient employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer phone & direct extension: _____

Spouse's employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency contact: _____ Relation: _____

Phone number: _____ Home Cell Phone

Please indicate if you have the following: Living Will Durable Power of Attorney

Family doctor: _____ Phone number: _____

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

Patient Name _____

Dietary History

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

			Date(s)	Duration	MD Supervised (circle one)	Max Loss
Jenny Craig	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nutri-Systems	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weight-Watchers	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Opti/Medi Fast	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fen/Phen/Redux	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meridia	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Atkins	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
T.O.P.S.	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Curves	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
South Beach	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cutting Calories / Low Fat	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	

List all other diets and/or weight loss attempts: _____

Lowest weight in past 5 years: _____ Highest weight in past 5 years: _____

Food Preferences

Indicate which foods would most likely make you go off a diet:

- | | | | | |
|---------------------------------------|---------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> candy | <input type="checkbox"/> ice cream | <input type="checkbox"/> cakes/pies | <input type="checkbox"/> steaks/chops | <input type="checkbox"/> pizza |
| <input type="checkbox"/> potatoes | <input type="checkbox"/> fried foods | <input type="checkbox"/> salad dressings | <input type="checkbox"/> pasta | <input type="checkbox"/> soda/soft drinks |
| <input type="checkbox"/> chips/snacks | <input type="checkbox"/> french fries | <input type="checkbox"/> cookies | <input type="checkbox"/> chocolate | |

Which surgery are you considering?

- LapBand Gastric Bypass Gastric Sleeve Duodenal Switch

Weight-Related Illnesses

Have you had, or do you have, any of the following illnesses or symptoms?

		<i>Provider Comments</i>
1. Heart Disease Year diagnosed: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Name _____

3. High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Sleep Apnea Syndrome Setting: _____ Last sleep study(month/year): _____ CPAP used <input type="checkbox"/> Yes <input type="checkbox"/> No Setting: _____ Morning headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Daytime drowsiness <input type="checkbox"/> Yes <input type="checkbox"/> No Restless sleep <input type="checkbox"/> Yes <input type="checkbox"/> No Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No Awakenings at night <input type="checkbox"/> Yes <input type="checkbox"/> No Observed apnic episodes <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Sleep study ordered.</i> _____ <i>(initials)</i>
9. History of Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Heartburn/Esophagitis/Hiatus Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Gallbladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Leakage of Urine with laughing/ coughing/sneezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Low Back Strain/Pain/Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Pain in Weight Bearing Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Walk unassisted If no, do you use a: cane <input type="checkbox"/> Yes <input type="checkbox"/> No walker <input type="checkbox"/> Yes <input type="checkbox"/> No wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No		
16. Swelling in Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Thyroid Disease Are you presently taking medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Irregular Periods or Infertility (for female patients only) If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. History of repeated Skin Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20. History of Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Name _____

Exercise

What type of exercise/activity do you perform routinely (if applicable)?

Type of Exercise	Duration (how long each time)	Frequency (times per week)	Provider Comments

Health History

Please list below all serious illnesses, surgeries, and hospitalizations you have experienced.

Major illness	Date	Treatment

Major Surgery	Date	Open or Laparoscopic

Do you use tobacco? Yes No Frequency _____

Are you willing to quit? Yes No

* Please note: the Surgical Weight Loss Center will be performing random nicotine screenings on smokers.

Do you use alcohol? Yes No Frequency _____

Do you use illegal substances? Yes No Frequency _____

Medication Allergies: Yes No

If yes, please list medication and reaction: _____

Surgical Tape / Suture Allergies: Yes No If yes, please list reaction. _____

Latex Allergies: Yes No If yes, please list reaction. _____

