Office Use Only:

Received: _____ **Database:** _____ **Insurance: Y/ N per** _____

Paperwork sent: _____ **Consult appointment:** _____**with TS or LR**

Sentara Martha Jefferson **Bariatric Care Center**

Medical History Questionnaire

Please fill out this questionnaire completely. DO NOT LEAVE ANY QUESTIONS BLANK. If the question does not apply, please put "N/A."

Current Height: _____ Current Weight: _____ Heaviest Weight: _____ BMI: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: ☐ M ☐ F

Phone: (cell) _____ (work) _____ (home) _____

Email: _____ Occupation: _____

Employer: _____ Full-time/Part-time: _____

Insurance Co. _____ Phone: _____

Policy # _____ Group # _____

2nd Insurance Co. _____ Phone # _____

Policy # _____ Group # _____

Primary Physician:_____Phone # _____

Address: _____

Other Physicians Seen Recently: _____

Select procedure most interested in:

☐ Gastric Bypass ☐ Gastric Sleeve ☐ Duodenal Switch ☐ Revision

Date You Attended/ Viewed Seminar: _____

Signature: _____ Date: _____

PLEASE READ: If you have health insurance, we strongly recommend that you call your insurance company in advance to determine coverage and/or exclusions for weight-loss surgery. If you do not have insurance coverage for weight-loss surgery, you may pay cash or you may secure your own financing (not available through Martha Jefferson Hospital).

How many years have you been overweight? _____

Diet programs and supplements: Please indicate which of the following diets or programs you have previously attempted.

Program	Dates	MD supervised?	Pounds Lost	Reason for Stopping
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutri/System				
Atkins Diet				
Herbalife				
SlimFast				
Grapefruit Diet				
Liquid Diets				
Optifast				
Paleo Diet				
Whole 30				
Keto Diet				
Advocare				

List any other physician-supervised weight-loss attempts:

_____

_____

What is your primary motivation for pursuing weight-loss surgery?

_____

Who will be your primary support before and after surgery? _____

Weight-Loss Medication History: Please indicate if you have taken any of the following medications for the purpose of losing weight.

FDA Approved Medication	Dates	Duration	Pounds Lost
Xenical (Orlistat/ Amil)			
Belviq (Lorcaserin)			
Qsymia (Topiramate)			
Contrave (Naltrexone/ Bupropion)			
Saxenda (Liruglutide)			
Phentermine (Adipex/ Fastin, Pondimin)			
Phen-Fen			
Sibutramine (Meridia)			
Other Diet Medications:			

Non-Dietary Therapies: Please indicate if you have tried any of the following weight-loss therapies.

Therapy:	Dates	Duration	MD supervised?	Pounds Lost
Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Previous Weight-Loss Surgery: Have you ever had surgery for the purpose of losing weight?

☐ No ☐ Yes If yes, please answer info below:

Surgery Type **Location/ Hospital** **Date** **Surgeon** **Pounds Lost**

Obesity-Related Medical History:

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

Heart Disease	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Do you have, or have you had:		
Angina	☐ Yes	☐ No
Heart attack or myocardial infarction	☐ Yes	☐ No
Coronary bypass surgery	☐ Yes	☐ No
Palpitations (abnormal heart beat)	☐ Yes	☐ No
Heart valve problems	☐ Yes	☐ No
Pulmonary hypertension	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
High Blood Pressure	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Do you take prescription medications for this?	☐ Yes	☐ No
Hyperlipidemia	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Elevated Cholesterol	☐ Yes	☐ No
Elevated Triglycerides	☐ Yes	☐ No
Diabetes	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Juvenile onset	☐ Yes	☐ No
Gestational (Pregnancy-induced)	☐ Yes	☐ No
Adult onset	☐ Yes	☐ No
Diet controlled	☐ Yes	☐ No
Oral Medications	☐ Yes	☐ No
Insulin	☐ Yes	☐ No
Pulmonary Disease	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
If so, how many blocks are you able to walk?_____		
How many flight of stairs can you climb? _____		
Have you been diagnosed by a Physician with Sleep Apnea?	☐ **Yes**	☐ **No**
If yes, do you use a CPAP or BiPAP machine?	☐ Yes	☐ No
Reflux/Heartburn/Esophagitis	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Do you take prescription medications for this?	☐ Yes	☐ No
Over-the-counter medications?	☐ Yes	☐ No
Frequency of use: _____		
Have you been diagnosed with a hiatal hernia?	☐ Yes	☐ No
If so, how long ago? _____		
Have you had an endoscopy (EGD)?	☐ Yes	☐ No

Pain or Arthritis of Ankles/Knees/Hips	☐ **Yes**	☐ **No**
Does this limit your ability to walk or exercise?	☐ Yes	☐ No
Do you take prescription medications for this?	☐ Yes	☐ No
Over-the-counter medications?	☐ Yes	☐ No
If so, how often? _____		
Low Back Pain/Sciatica	☐ **Yes**	☐ **No**
Does this limit your ability to walk or exercise?	☐ Yes	☐ No
Do you take prescription medications for this?	☐ Yes	☐ No
Over-the-counter medications?	☐ Yes	☐ No
If so, how often? _____		
Urinary Incontinence (leakage of urine)	☐ **Yes**	☐ **No**
With coughing/sneezing/straining	☐ Yes	☐ No
Number of times per week: _____		
Migraine Headaches	☐ **Yes**	☐ **No**
Frequency: _____		
Do you take prescription medications for this?	☐ Yes	☐ No
Over-the-counter medications?	☐ Yes	☐ No
If so, how often? _____		
Deep Venous Thrombosis (Blood clots in legs)	☐ **Yes**	☐ **No**
If yes, year of diagnosis: _____		
Pulmonary embolism	☐ Yes	☐ No
Blood thinning medication	☐ Yes	☐ No
Venous stasis (leg or ankle swelling, ulceration, color change)	☐ Yes	☐ No
Abdominal Wall Hernia	☐ **Yes**	☐ **No**
Incisional	☐ Yes	☐ No
Umbilical (belly button)	☐ Yes	☐ No
Have you been diagnosed with a hernia?	☐ Yes	☐ No
Previous hernia repairs?	☐ Yes	☐ No

Past Medical History:

Please list all medical conditions or illnesses not previously mentioned in this questionnaire:

Past Surgical History:

Please list all surgical procedures or operations you have had:

Procedure	Reason	Hospital	Date

Do you have allergies to any medications? ☐ **Yes** ☐ **No**

If yes, please list medications and reactions (e.g., rash, difficulty breathing, shock, etc.):

Have you ever received a blood transfusion? ☐ Yes ☐ No

Have you ever had Hepatitis? ☐ Yes ☐ No

Have you ever been exposed to HIV/AIDS? ☐ Yes ☐ No

Have you ever abused intravenous (IV) drugs? ☐ Yes ☐ No

Medications: Please list all medications you currently use, including non-prescription medications, vitamins, dietary supplements, and herbal remedies.

Name of Medication	Dosage & Frequency	Reason

Family History:

Please indicate which **family member** has had any of the following illnesses:

☐ Obesity	☐ Lung disease or emphysema	☐ Kidney Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes
☐ Heart Disease	☐ Breast Cancer	☐ Blood Disorder
☐ Stroke	☐ Other Cancers	☐ Bleeding Tendency

Is your mother still alive? ☐ Yes ☐ No

If not, what was the cause of death and age at death? _____

Is your father still alive? ☐ Yes ☐ No

If not, what was the cause of death and age at death? _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No If yes, how many? _____

Occupation: _____

Do you use tobacco? ☐ Yes ☐ No If yes:

Cigarettes: Number packs per day: _____ Years of tobacco use: _____

Cigars: Number per day: _____ Years of tobacco use: _____

Pipe: Number times per day: _____ Years of tobacco use: _____

Smokeless (snuff/ chew): Number times per day: _____ Years of tobacco use: _____

Vape/ E-Cigarettes: Frequency of use: _____ How many years?_____

Cannibas/ Marijuana: Frequency of use: _____ How many years?_____

Do you use alcohol? ☐ No ☐ Yes Amount and frequency: _____

Have you ever been treated for depression? ☐ Yes ☐ No

Are you currently in treatment? ☐ Yes ☐ No

If yes, please indicate the name of your physician or therapist/counselor:

_____

Have you ever been hospitalized for mental illness? ☐ Yes ☐ No

If yes, please indicate date(s) and reason(s):

_____

Review of Body Systems:

Please check any of the following you currently experience or have experienced in the past:

General

☐ Fever
☐ General Weakness
☐ Memory Loss
☐ Easy Bruising
☐ Abnormal Bleeding
☐ Fatigue
☐ Tiredness
☐ Recent Weight Loss
☐ Night Sweats
☐ Other _____

Head/Neck

☐ Trouble with vision
☐ Persistent hoarseness
☐ Fainting spells
☐ Difficulty swallowing
☐ Trouble with ears
☐ Severe headaches
☐ Loss of smell
☐ Pain when swallowing
☐ Sinus trouble
☐ Dizziness
☐ Sore throat
☐ Lump in neck
☐ Other _____

Chest/Heart/Lungs

- ☐ Shortness of breath
- ☐ Fluttering of heart
- ☐ Coughing up blood
- ☐ Heart attack
- ☐ Palpitations
- ☐ Low blood pressure
- ☐ Pain in legs
- ☐ Emphysema
- ☐ Difficulty sleeping flat
- ☐ Poor exercise tolerance
- ☐ Frequent cough
- ☐ Swollen ankles
- ☐ Pain in arms or neck
- ☐ Heart murmur
- ☐ Stroke
- ☐ Asthma
- ☐ Pneumonia
- ☐ Waking at night short of breath
- ☐ Chest pain or pressure attacks.
- ☐ Wheezing
- ☐ Night sweats
- ☐ Heart pounding
- ☐ Abnormal heart beats
- ☐ Cold feet
- ☐ Loss of pulses
- ☐ Bronchitis
- ☐ Other _____

Stomach/Intestines/Abdomen

- ☐ Poor appetite
- ☐ Nausea or vomiting
- ☐ Abdominal swelling
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Heartburn
- ☐ Change in stool size
- ☐ Colitis
- ☐ Indigestion or heartburn
- ☐ Vomiting blood
- ☐ Diarrhea
- ☐ Pass blood from rectum
- ☐ Hepatitis
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Difficulty swallowing
- ☐ Abdominal pain or cramps
- ☐ Constipation
- ☐ Black, tar-like bowel movements
- ☐ Cirrhosis
- ☐ Pain with bowel movements
- ☐ Irritable bowel
- ☐ Other _____

Kidneys/Urinary

- ☐ Kidney stones
- ☐ Difficulty passing urine
- ☐ Frequent urination
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Difficulty controlling urine
- ☐ Leakage of urine
- ☐ Pelvic examination/PAP smear within past year
- ☐ Pain/burning while urinating
- ☐ Getting up at night to urinate
- ☐ Kidney infection
- ☐ Other _____

Bones/Joints

- ☐ Weakness in arm or leg
- ☐ Loss of muscle strength
- ☐ Lump or swelling in muscle
- ☐ Pain in knees
- ☐ Pain in ankles
- ☐ Numbness in feet or legs
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Arthritis
- ☐ Pain in hips
- ☐ Sciatica
- ☐ Herniated disk
- ☐ Gout
- ☐ Back pain
- ☐ Muscular aches
- ☐ Pain in feet
- ☐ Low back pain
- ☐ Abnormal lumps or masses
- ☐ Other _____

Endocrine

☐ Hyperthyroid ☐ Low thyroid ☐ Goiter
☐ Previous radiation ☐ Diabetes ☐ Adrenal gland tumor
☐ Swollen glands ☐ Cold when others are not ☐ Hot when others are not
☐ Persistent thirst ☐ Previous steroid (corticosteroids, cortisone) use or injections
☐ Other _____

Skin

☐ Changing mole ☐ Rash ☐ Burns
☐ Skin cancer
☐ Other _____

Muscular/Nervous System

☐ Seizures ☐ Convulsions ☐ Fainting
☐ Dizziness ☐ Light headedness ☐ Falling
☐ Muscle weakness ☐ Numbness ☐ Tremors
☐ Loss of consciousness ☐ Strokes
☐ Other _____

Psychological

☐ Depression ☐ Nervousness ☐ Suicidal thought
☐ Suicide attempts ☐ Schizophrenia ☐ Anorexia
☐ Bulimia ☐ Binge eating ☐ Mental health counseling
☐ Hospitalization for emotional problems

How would you describe your life?

☐ Unsatisfactory ☐ Satisfactory ☐ Boring ☐ Other

Do you: ☐ Cry easily? ☐ Feel anxious or upset? ☐ Have difficulty with sleep?

☐ Other _____

Females only

Date of last mammogram:_____

☐ Breast lump ☐ Discharge from nipple ☐ Hot flashes
☐ Possibly pregnant ☐ Irregular periods ☐ Vaginal discharge
☐ Vaginal bleeding or spotting (between periods)
☐ Other _____

Males only

☐ Prostate trouble ☐ Discharge from penis ☐ Sores on penis
☐ Lump in testicles ☐ Difficulty having erections
☐ Other _____