

**Office Use Only:**

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Paperwork sent: \_\_\_\_\_ Consult appointment: \_\_\_\_\_ with JS

*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: \_\_\_\_\_ BMI: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex:    M / F   

Phone: (cell) \_\_\_\_\_ (work) \_\_\_\_\_ (home) \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Full-time/Part-time:    FT / PT   

Insurance Co. \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.**

2<sup>nd</sup> Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Other Physicians Seen Recently: \_\_\_\_\_

Circle procedure most interested in: Gastric Bypass    Gastric Sleeve    Orbera balloon

**Date You Attended 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.

<b>Program</b>	<b>Dates</b>	<b>Duration</b>	<b>MD supervised?</b>	<b>Pounds Lost</b>
Weight Watchers	_____	_____	_____	_____
Jenny Craig	_____	_____	_____	_____
Metabolife	_____	_____	_____	_____
Medifast	_____	_____	_____	_____
Nutri/System	_____	_____	_____	_____
Atkins Diet	_____	_____	_____	_____
Herbalife	_____	_____	_____	_____
SlimFast	_____	_____	_____	_____
Grapefruit Diet	_____	_____	_____	_____
Liquid Diets	_____	_____	_____	_____
Pritikin Diet	_____	_____	_____	_____
Optifast	_____	_____	_____	_____
T.O.P.S.	_____	_____	_____	_____

List any other physician-supervised weight-loss attempts:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

<b>Medication:</b>	<b>Dates</b>	<b>Duration</b>	<b>MD supervised?</b>	<b>Wt. Lost</b>
Sibutramine (Meridia)	_____	_____	_____	_____
Phen-Fen	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____
Phentermine (Adipex, Fastin, Pondimin)	_____	_____	_____	_____
Dexfenfluramine (Redux)	_____	_____	_____	_____
Xenical (Orlistat)	_____	_____	_____	_____
Other Diet Medications:	_____	_____	_____	_____

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

<b>Therapy:</b>	<b>Dates</b>	<b>Duration</b>	<b>MD supervised?</b>	<b>Pounds Lost</b>
Exercise	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Behavior Modification	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____

List any other weight-loss methods you have previously tried:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, please answer info below:

<b>Surgery Type</b>	<b>Date</b>	<b>Surgeon</b>	<b>Pounds Lost</b>
_____	_____	_____	_____
_____	_____	_____	_____

**Obesity-Related Medical History:**

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

<b>Heart Disease</b>	<b>Yes</b>	<b>No</b>
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
<b>Congestive Heart Failure</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
<b>High Blood Pressure</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
<b>Elevated Cholesterol</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
<b>Elevated Triglycerides</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
<b>Diabetes</b>	<b>Yes</b>	<b>No</b>
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
<b>Asthma</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
<b>Shortness of Breath</b>	<b>Yes</b>	<b>No</b>
If yes, you can walk _____ blocks and climb _____ flights of stairs		
<b>Have you been diagnosed by a Physician with Sleep Apnea?</b>	<b>Yes</b>	<b>No</b>
If yes, do you use a CPAP or BiPAP machine?	Yes	No
Have you had corrective surgery?	Yes	No
Has anyone told you that you stopped breathing while sleeping?	Yes	No
Sleep difficulties:      Snoring	Yes	No
Awakenings at night	Yes	No
Daytime drowsiness	Yes	No
Observed apnea spells	Yes	No
Morning headaches	Yes	No

<b>Reflux/Heartburn/Esophagitis/Hiatal Hernia</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
Prescription medications:	Yes	No
Over the counter medications:	Yes	No
Frequency of use: _____		
Endoscopy:	Yes	No
<b>Venous Stasis</b>	<b>Yes</b>	<b>No</b>
Leg or ankle swelling/edema	Yes	No
Leg ulceration	Yes	No
Leg skin color change or thickening	Yes	No
<b>Pain or Arthritis of Ankles/Knees/Hips</b>	<b>Yes</b>	<b>No</b>
Limits ability to walk or exercise	Yes	No
Prescription medications	Yes	No
Over the counter medications	Yes	No
<b>Low Back Pain/Sciatica</b>	<b>Yes</b>	<b>No</b>
Limits ability to walk or exercise	Yes	No
Prescription medications	Yes	No
Over the counter medications	Yes	No
<b>Urinary Incontinence (leakage of urine)</b>	<b>Yes</b>	<b>No</b>
With coughing/sneezing/straining	Yes	No
Number of times per week: _____		
<b>Migraine Headaches</b>	<b>Yes</b>	<b>No</b>
Frequency: _____		
Prescription medications	Yes	No
Over the counter medications	Yes	No
<b>Deep Venous Thrombosis (Blood clots in legs)</b>	<b>Yes</b>	<b>No</b>
If yes, year of diagnosis: _____		
Pulmonary embolism	Yes	No
Blood thinning medication	Yes	No
<b>Abdominal Wall Hernia</b>	<b>Yes</b>	<b>No</b>
Incisional	Yes	No
Umbilical (belly button)	Yes	No
Number of hernia repairs and dates:		
_____		
Hernia currently present	Yes	No

**Past Medical History:**

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

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Please list all nonsurgical hospitalizations you have experienced as an adult:

<b>Reason</b>	<b>Hospital</b>	<b>Date</b>
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**Past Surgical History:**

Please list all surgical procedures or operations you have had:

<b>Procedure</b>	<b>Reason</b>	<b>Hospital</b>	<b>Date</b>
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**Do you have allergies to any medications?**                       **Yes**                       **No**

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

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- 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> Lung disease or emphysema | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Breast Cancer             | <input type="checkbox"/> Blood Disorder    |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Other Cancers             | <input type="checkbox"/> 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: Number times per day: \_\_\_\_\_ Years of tobacco use: \_\_\_\_\_

Do you use alcohol?  No     Yes    Amount and frequency: \_\_\_\_\_

Do you use recreational drugs?  No     Yes    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 circle any of the following you currently experience or have experienced in the past:

**General**

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

**Head/Neck**

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



Other \_\_\_\_\_

**Chest/Heart/Lungs**

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

Other \_\_\_\_\_

**Stomach/Intestines/Abdomen**

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

Colitis

Other \_\_\_\_\_

**Kidneys/Urinary**

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

Other \_\_\_\_\_

**Bones/Joints**

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

Breast lump	Discharge from nipple	Hot flashes
Possibly pregnant	Irregular periods	Mammogram within past year
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 _____		