**Medical and Patient Information Questionnaire (Doc-01)**

Date:

**Patient Information**

First Name: Last Name:

Date of Birth:  Age: Sex: (M or F) Race:

Mailing Address:

City: State: Zip:

Social Security:

|  |  |
| --- | --- |
| **Contact Information** | **Best way to contact** (Check all that apply) |
| Home Phone |  |
| Work Phone |  |
| Cell Phone |  |
| Email |  |

**Marital Status:**

Single  Married  Domestic Partner  Divorced  Widowed Years

Spouse or Significant Other’s Name:

Children:  Yes  No Ages

Education:  High School  Some College  College Graduate

Graduate Degree  Professional Degree

**Pharmacy:**

Name:

Address:

City: State: Zip:

Phone number: Fax number:

**Employment**

Occupation: Employer:

Employer Address:

Work Phone: May we contact you at work? (Yes/No)

**Emergency Contact Information**

Name: Relationship:

Home Phone: Work Phone: . Cell Phone: .

Address:

City: State: Zip:

**Referring or Primary Care Physician**

Name:

Phone:  Fax: .

Address:

City: State: Zip:

Have your discussed weight loss surgery with your Physician? (Yes/No)

|  |  |
| --- | --- |
| **Exams** | **Last Date** |
| Complete physical exam |  |
| Lab Work (Blood Test) |  |
| Chest X-Ray / EKG | / |
|  |  |
|  |  |
| **Female Patients Only** | |
| Age of first period: | Regular: (Yes/No) |
| Date of last Menstrual Cycle |  |
| Number of pregnancies past first trimester / Live birth | / |

**Social Habits**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Ever used** | **How much** | **Since (date)** | **If stopped when (date)** |
| Smoking | (Yes/No) |  |  |  |
| Other tobacco | (Yes/No) |  |  |  |
| Alcohol | (Yes/No) |  |  |  |
| Other drugs (specify) | | |  |  |

**Weight Loss Programs You Have Tried**

|  |  |  |
| --- | --- | --- |
| Jenny Craig | Atkins | Acupuncture |
| MediFast/ OptiFast | Nutrisystem | Phen Fen |
| Slim Fast | Weight Watchers | Xenical |
| Metabolife | Meridia | Redux |

Other Programs:

Can you provide the records or receipts for any of the above programs: (Yes/No)

**Height /Weight information**

|  |  |  |
| --- | --- | --- |
| **Provide the best estimate** | **Height** | **Weight** |
| Height/Weight in **Jr. High School** |  |  |
| Height/Weight in **High School** |  |  |
| **Lowest** weight as an adult |  |  |
| **Highest** weight as an adult |  |  |
| Your Last known |  |  |

Family members >50 lbs over weight

**Allergies**

|  |  |
| --- | --- |
| **Medication or Food** | **Symptoms (Nausea, shortness of breath etc)** |
|  |  |
|  |  |
|  |  |

**Medications** (may attach a list if available)

|  |  |
| --- | --- |
| **Name** | **Dosage and frequency** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Previous Surgeries**

|  |  |
| --- | --- |
| **Operation (including C-section)** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Past Medical problems**

Check all that apply (Diagnostic codes are for internal use)

|  |  |
| --- | --- |
| **Cardiovascular**  Arrhythmia -Irregular heart rhythm I49.9  History of Heart Attack Z86.74  High Blood Pressure (HTN) I10  Congestive heart failure (CHF) I50.9  Venous insufficiency (peripheral) I87.2  Swelling of ankles M25.473 | **Musculoskeletal**  Arthritis – weight bearing joints M12.9  Joint pain – weight bearing joints M25.50  Joint pain – Back M25.50  Joint pain – Foot M25.579  Joint pain – Hip M25.559  Joint pain – Knee M25.569 |
| **Gastrointestinal**  Difficulty swallowing R13.10  Reflux Disease (GERD) K21.9  Heartburn R12  Cholelithiasis -Gall stones K80.20  Fatty liver K76.0 | **Neuro-Psycho-Social conditions-stressors**  Anxiety disorder F41.9  Bipolar disorder F31.9  Depression F32.9  History of alcohol abuse Z65.8  Panic disorder F41.0  Pseudotumor Cerebri G93.2 |
| **Endocrine**  Diabetes Mellitus type II E11.9  Hypothyroidism E03.9  Hyperlipidemia E79.0  Low Calcium - Hypocalcemia E83.51  Hyperparathyroidism E21.3  Hypoglycemia, unspecified 251.2 |
| **General complaints and**  **Complications of previous WLS (if any)**  Abdominal pain R10.09  Anemia D64.9  Anorexia (loss of appetite) R63.0  Bezoar Obstruction – Food blockage R18.2XXA  Dumping syndrome K91.1  Hair loss L65.9  Nausea R11.0  Protein-calorie malnutrition E46  Pulmonary Embolism – post operative I26.99  Others not listed (write in please): |
| **Respiratory System**  Asthma – unspecified J45.909  Snoring R06.83  Snort or gasp- at night – wakes you up R06.89  Obstructive sleep apnea G47.33  Unspecified sleep apnea G47.30 |
| **Urinary**  Frequent urination R35.0  Urinary stress incontinence – Female N39.3  Urinary stress incontinence – Male N39.3 |
| **Gynecological**  Heavy periods N92.0  Amenorrhea (no periods) N91.2  Infertility N92.6  Irregular periods N92.6  Dysmenorrhea – Painful periods N94.6  Polycystic ovary disease E28.2 |

**Miscellaneous Information**

Do you take Vitamins? (Yes/No) Daily? (Yes/No)

Do you smoke? (Yes/No) Number of packs: Number of years:  .

Quit? (Yes/No) When?

Do you drink any alcoholic beverages: (Yes/No) If yes, type?

Do you or have you used any illicit drugs: (Yes/No) If yes, ttype:

How Long: When was the last time you used: .

Do you live alone: (Yes/No)

Do you care for young children or any elderly: (Yes/No)

List household members (Names & ages):

*The information completed in this packet is true and correct to the best of my belief*

Print your name:  Date:

Signature: