**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: