

SURGICAL BARIATRICS NORTHWEST

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Phone: 208-262-0945
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Health Questionnaire

Patient Name: _____

Date of birth: _____

Date: _____

Age: _____ **Height:** _____ **Weight:** _____ **BMI:** _____

Personal Physicians:

Primary care _____

Internist _____

Other:

Pulmonary _____

Endocrine _____

History of Present Illness:

Describe briefly your present medical symptoms or problem you are seeing the doctor for:

How long have you had symptoms? _____

Describe severity of your symptoms _____

Weight management history:

(Details are crucial in order to obtain insurance benefits.)

Diet history:

Current weight _____ Maximum weight _____

First time obesity: Y Noted: Lifelong _____ High school _____ After children _____

Later _____ Your weight at high school graduation _____

Unsupervised diets:

Program	Year	# Months	Wt. Loss	Wt. Regained
High Protein				
Grapefruit				
Slim Fast				
Other				

Supervised diets:

Program	Year	# Months	Wt. Loss	Wt. Regained
Jenny Craig				
Diet Centers				
Medi Fast/ OptiFast/ Liquid Rx Protein				
Hypnosis				
Exercise				
Overeaters Anon.				
Acupuncture				
Nutritionist				
Psychiatrist/Therapy				
Previous surgery				
Weight Watchers				
Name of Surgeon				

Drug/Food Allergies: _____

Medication(s)	Dosage	Frequency

Previous Surgeries	Year

Surgical Complication	Yes	No
Bleeding		
Anesthesia Problems		
Infection		
Blood Transfusion		
Post-op nausea/vomiting		
Airway management problems		

Social History:

Marital Status: S M W D

Occupation: _____

Employed: Y N How long: _____

Smoker: Never ___ Yes ___ Quit (date) _____ Packs per day _____

Do you drink: Never ___ Social ___ Seldom ___ Frequent ___ Former Alcoholic _____

Street drugs: Y N Which ones _____

Coffee/caffeine use: None ___ Cups per day _____

Carbonated beverages: Y N per day _____

Family History:

Obesity: Y N # _____ of deaths related to obesity

Heart disease: Y N

Diabetes mellitus: Y N

High blood pressure: Y N

Lung problems: Y N

Bleeding disorder: Y N

Gallstones: Y N

Cancer: Y N

Specify type: _____

Malignant hyperthermia: Y N

Review of Systems:

Do you have any of the following conditions:

1. Constitutional:

Fevers: Y N

Weight loss: Y N

Night sweats: Y N

Chronic fatigue: Y N

Anemia: Y N

Hair loss: Y N

Skin changes/ problems: Y N

Comments/description _____

2. Head and Neck:

Wear contacts/glasses: Y N
Swallowing difficulty: Y N
Vision problems: Y N
Dentures/partial: Y N
Hearing problems: Y N
Oral sores: Y N
Sinus drainage: Y N
Any surgery: Y N
Neck lumps: Y N
Hoarseness: Y N
Snoring, sleep apnea: Y N
Frequent severe headaches: Y N
Convulsion/seizure: Y N
Knocked unconscious: Y N

Comments/description _____

3. Heart, Blood vessels:

Heart attack: Y N
Varicose veins: Y N
Angina: Y N
Hemorrhoids: Y N
Rhythm disturbance/Phlebitis: Y N
Palpitations: Y N
Foot ulcers: Y N
Congestive heart/Bypass/valve replacement/failure: Y N
Pacemaker: Y N
High blood pressure: Y N
Clogged arteries: Y N
Ankle swelling: Y N
Other symptoms: Y N
Comments/description _____

4. Lung function:

Asthma: Y N
Tuberculosis: Y N
Emphysema: Y N
Pulmonary embolism: Y N

Bronchitis: Y N
Hypoventilation syndrome: Y N
Pneumonia: Y N
Surgery: Y N
Chronic cough: Y N
Cough up blood: Y N
Short of breath: Y N
Sleep apnea: Y N
Use of CPAP or oxygen supplement: Y N
Comments/description _____

5. Breast:

Cancer: Y N
Fibrocystic disease: Y N
Lumps: Y N
Surgery: Y N
Pain: Y N
Nipple discharge: Y N
Comments/description _____

6. Intestinal:

Heartburn/indigestion: Y N
Enlarged liver: Y N
Ulcers: Y N
Cirrhosis/hepatitis: Y N
Diarrhea: Y N
Gallbladder problems: Y N
Blood in stool: Y N
Fissure: Y N
Change in bowel habit: Y N
Rectal bleeding: Y N
Constipation: Y N
Polyps: Y N
Irritable bowel: Y N
Surgery: Y N
Colitis/Crohn's: Y N
Hernia: Y N
Hemorrhoids: Y N
Pancreatic disease: Y N
Cancer: Y N

Jaundice: Y N
Abdominal pain: Y N
Unusual vomiting: Y N
Hiatal hernia: Y N
Black, tarry stools: Y N
Comments/description _____

7. Bladder, Kidney:

Stones: Y N
Surgery: Y N
Blood in urine: Y N
Burning: Y N
Prostate problems: Y N
Loss of bladder control: Y N
Renal failure: Y N
Cancer: Y N
Leaking urine: Y N
Prostate trouble: Y N
Had a PSA test: Y N
Trouble starting urine: Y N
Comments/description _____

8. Musculoskeletal:

Arthritis: Y N
Cancer: Y N
Neck pain: Y N
Surgery: Y N
Back pain: Y N
Fibromyalgia: Y N
Hip/knee pain: Y N
Broken bones: Y N
Muscle pain/spasm: Y N
Joint replacement: Y N
Shoulder pain: Y N
Nerve injury: Y N
Conditions or problems related to ability to walk or stand: Y N
Muscular dystrophy: Y N
Comments/description _____

9. Immune and blood function:

Anemia: Y N

Swollen lymph nodes: Y N

HIV: Y N

Bleeding disorder: Y N

Low platelets: Y N

Blood transfusion: Y N

Lymphoma: Y N

Blood thinning medicine: Y N

Comments/description _____

10. Neurologic:

Migraine headaches: Y N

Stroke: Y N

Balance disturbance: Y N

Alzheimer's: Y N

Seizure: Y N

Surgery: Y N

Weakness: Y N

Multiple sclerosis: Y N

Comments/description _____

11. Psychiatric:

Depression: Y N

Drug dependency: Y N

Bulimia: Y N

Anxiety: Y N

Other psychiatric problems: Y N

Alcoholism: Y N

Anorexia: Y N

Schizophrenia: Y N

Bipolar: Y N

Have you ever been in a psychiatric hospital: Y N

Have you ever attempted suicide: Y N

Have you ever seen a psychiatrist or counselor: Y N

Have you ever taken medications for psychiatric problems: Y N

Have you ever been in a chemical dependency program: Y N

Comments/description _____

12. Endocrine:

Thyroid problems: Y N
Low blood sugar: Y N
Goiter: Y N
Diabetes: Y N
Parathyroid: Y N
Endocrine gland tumor: Y N
Elevated cholesterol: Y N
Cancer: Y N
Elevated triglycerides: Y N
Abnormal facial hair growth: Y N
Comments/description _____

13. For Women Only:

Are you pregnant: Y N
Menstrual irregularity: Y N
Births: Y N
Menstrual pain: Y N
Uterine/Ovarian Cancer: Y N
Date last PAP smear _____
Surgery: Y N
Date last menstrual period _____
Age started menses _____
Number of pregnancies _____
Number of births _____
Do you plan to have more children: Y N
Comments/description _____

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