Initial Medical Questionnaire

Please complete this questionnaire and bring it with you to your first appointment.

Name:_____

Address: _____
Street City State Zip Code

Home phone: _____ **Cell phone:** _____**Work phone:** _____

Email (please print clearly): _____

Birth date: _____ **Social Security #:**_____

Insurance plan: _____ **Plan ID#:** _____

Did you call your insurance company? **Yes** **No** Is bariatric surgery a covered benefit? **Yes** **Unsure**
Does your insurance company require a referral for specialist? **Yes** **No**

I am interested in: ☐ **Gastric Bypass** ☐ **Gastric Sleeve** ☐ **Conversion** ☐ **Unsure**

Pharmacy: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____

Address: _____
Relation to you: ☐ spouse ☐ child ☐ parent ☐ friend ☐ Health Care Proxy

Primary Care Physician:_____ Phone: _____

Address: _____
Is PCP at Lowell Community Health Center? **Yes** **No**
Is PCP a part of Atrius Health? **Yes** **No**

Cardiologist: _____ Phone: _____

Address: _____

Other Physician: _____ Phone: _____

Address: _____

Have you discussed weight loss surgery with your primary care physician? **Yes** **No**
Does your primary care physician feel weight loss surgery is a good choice for you? **Yes** **No**
Has any of your friends or family undergone weight loss surgery? **Yes** **No**

If yes, describe:_____

How did you hear about us? ☐Internet ☐friend ☐family ☐physician ☐advertisement ☐other:_____

Dieting and Weight History

How long has your weight been a problem?
Since: ☐Childhood ☐Adolescence ☐Early Adulthood ☐Having children ☐Other: _____

What weight loss strategies have you used?

☐ Vomiting	☐ Weight Watchers	☐ Physician supervised	☐ Fad diet
☐ Laxatives	☐ Commercial meal replacements	☐ Dietitian	☐ Low fat diet
☐ Diuretics	☐ Severe calorie restriction	☐ Food diary/journal	☐ Low carb diet
☐ Prescription weight loss medication (i.e. Phenfen)	☐ Non-prescription weight loss medication (i.e. Alli, Dexatrim	☐ Liquid diet ☐ Monitoring intake	☐ Exercise

☐ Other: _____

The most weight I have ever lost is _____lbs. How long did you keep the weight off? _____

Physical Activity

Check all that apply:
☐ I currently exercise. Please describe: _____

I require the use of a: ☐ cane ☐walker ☐wheelchair Explain: _____

I have orthopedic surgery scheduled: ☐Yes ☐No Explain: _____

Medications

Please list all medications, vitamins, and supplements you currently take. Bring all of them to your first appointment.

Name	Dose (mg, mcg, units, etc.)	How often/when

Attach an additional list if necessary.

Allergies

Are you allergic to any medications? **Yes** **No** If yes, list each one and what happens when you take it: _____

_____

Are you allergic to any foods? **Yes** **No** Which ones:_____
Are you allergic to latex? **Yes** **No**
Do you have any other allergies? **Yes** **No** If yes, describe: _____

Medical History

Have you had any of the following? Check all that apply.

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Cancer

What kind:

- ☐ Ulcer Disease
- ☐ GI Bleed
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Heartburn/Reflux
- ☐ Kidney Disease
- ☐ Ulcer Disease
- ☐ GI Bleed
- ☐ Diabetes

- ☐ Neuropathy
- ☐ Thyroid Disease
- ☐ Polycystic Ovarian Disease
- ☐ Miscarriage
- ☐ Seizure/Convulsion
- ☐ Stroke
- ☐ Anemia
- ☐ HIV
- ☐ Coagulation (bleeding or clotting) problem

Mental Health History

Do you currently see a mental health provider? **Yes** **No**

Your current counselor: _____ Phone: _____

Your current psychiatrist: _____ Phone: _____

Have you received treatment for any of the following? Check all that apply.

- ☐ Depression
- ☐ Anxiety
- ☐ Life stressors (divorce, death in family, etc.)
- ☐ Other:

- ☐ Alcohol problems
- ☐ Drug problems
- ☐ Physical or sexual abuse

Comment: _____

Do you live with or are you in a relationship with anyone who hurts you, threatens you, or makes you afraid? **Yes** **No**

Surgical History

Have you ever had surgery? **Yes** **No**

When	Why /What operation	Which hospital

Have you ever been hospitalized for any other reason? **Yes** **No**

When	Why	Which hospital

Social History

Do you live alone? **Yes** **No**
If no, who lives with you?_____

Are you employed? **Yes** **No**
If yes, occupation: _____ Hours:_____

Does your weight interfere with your job? **Yes** **No**
If yes, explain:_____

Are you disabled? **Yes** **No**
If yes, what is your disability? _____

Last school grade completed? _____

Did you ever **smoke** cigarettes? **Yes** **No**

If you **currently smoke**, how many cigarettes do you smoke per day: less than 5 / 5-14 / 15-29 / 30+
How many years have you been smoking? _____

If you **no longer smoke**, what year did you quit? _____ How many years did you smoke? _____
How many cigarettes per day did you smoke? _____

Do you smoke cigars or chew tobacco or use a vaporizor? **Yes** **No**
If yes, describe (what, how often): _____

How much **alcohol** do you drink (1 drink = 1.5 oz. distilled spirits, 5 oz. wine, 12 oz. beer)?
( ) I don't drink.
( ) I don't drink and I am a recovering alcoholic. My last drink was: _____
( ) I drink daily. How many drinks daily: _____
( ) I drink weekly. How many drinks weekly: _____
( ) I drink only on weekends. How many drinks over the weekend: _____
( ) I drink monthly or socially. How often and how many:_____

Have you ever taken non-prescription "street" drugs? **Yes** **No**
If yes, describe all drugs used, the last time you used them, AND any treatment received
In the past or currently: _____

_____

Family History

Has anyone in your family had the following problems?

MGM = maternal grandmother MGF = maternal grandfather PGM = paternal grandmother PGF = paternal grandfather

Disease	**Family Member**									
Obesity	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
High Blood Pressure	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
High Cholesterol	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
Heart Disease	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
Diabetes	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
Cancer	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF
Other:	Dad	Mom	Brother	Sister	Son	Daughter	MGM	MGF	PGM	PGF

Review of Systems

Do you presently have any of the following?

Eyes, Ears, Nose & Throat	**Yes**	**No**
Frequent Headaches/Migraines		
Fainting		
Dizziness		
Loss of Hearing		
Loss of Vision		
Glaucoma		
Wear Glasses		
Wear Contacts		
Dentures/Partial Plate		

Cardiovascular	**Yes**	**No**
Chest Pain or Pressure		
Rapid or Irregular Heartbeat		
Swelling of legs or feet		

Respiratory	**Yes**	**No**
Shortness of Breath		
Chronic Cough		
Cough with Sputum		
Oxygen at Home		

Gastrointestinal	**Yes**	**No**
Ever had a colonoscopy?		
When: Where:		
Comments:		
Ever had an upper endoscopy (EGD)?		
When: Where:		
Comments:		
Nausea		
Vomiting		
Constipation		
Diarrhea		
Abdominal pain		

Urinary	**Yes**	**No**
Pain when you pass urine		
Leaking of urine when you cough/sneeze		
Prostate issue (men only)		

Women's Health	**Yes**	**No**
Heavy periods		
Irregular periods		
Do you want to have (more) children?		

General Information

Do you require an interpreter? **Yes** **No** If yes, what language? _____

Did anyone assist you in completing this questionnaire? **Yes** **No** If yes, who? _____

How do you learn best? (check all that apply)

☐Listening ☐Reading ☐Writing notes ☐Watching a demonstration ☐Hands-on, participating

Do you have a **health care proxy** (someone to make medical decisions for you if you cannot)? **Yes** **No**

Dietary Information

Do you have a sweet tooth, crave sweets? **Yes** **No**
How many of your meals a day are prepared at home?_____ Comments: _____

How many of your meals a day are prepared by a restaurant or store?_____ Comments: _____

_____

How many times a day do you usually eat: _____
Circle the meals you usually have: **Breakfast** **Lunch** **Dinner** **Snack**(s): how many:_____

Please list everything you eat and drink in a typical day:

Foods / Drinks	What time?	Where? (at table, watching TV, car, restaurant, etc.)

Do you drink any of the following?

			What kind(s)/explain	How much and how often
Soda/seltzer/pop	Yes	No		
Coffee	Yes	No		
Tea	Yes	No		
Juice	Yes	No		
Energy drinks	Yes	No		
Milk	Yes	No		
Wine	Yes	No		
Beer	Yes	No		
Distilled spirits (vodka, etc.)	Yes	No		
Mixed alcoholic drinks	Yes	No		
Others:				

How often do you eat the following?

	Never/ 1 a month or less	2-3 times a month	1-2 times a week	3+ times a week	1-2 times a day	3+ times a day	Other amount/ comment
Fast food/Street food							
Fried foods							
Chips/Snackfoods							
Candy/Chocolate							
Desserts/Sweets							
Ice cream							
Fruit							
Vegetables/Salad							

Patient's signature _____ **Date:**_____

Provider's signature* _____ **Date:**_____

*My signature indicates that I personally reviewed the patient's history with the patient.