WITTGROVE BARIATRIC CENTER

Patient History Questionnaire

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough. Please type of use blue or black ink only.

Name:		Date:	
Age:	Gender: Male Female	Occupation: (If retired, what did you do?)	
---	Your Measurement	Nurse Consult Measurement	Pre-Operative Measurement
Actual Body Weight			
Height			
Ideal Body Weight			
Excess Body Weight			
Target Weight			
Body Frame (circle one) Small Medium Large	---	BMI:	BMI:
	---	Waist:	Waist:
	---	Hips:	Hips:

WEIGHT HISTORY

Please estimate as closely as possible for all that apply:

Life Event	Age	Weight
Birth	---	
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

_____

_____

_____

_____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program		Dates	Duration	Doctor Supervised?	Max Loss
Jenny Craig:	☐ Yes ☐ No				
Nutri-Systems	☐ Yes ☐ No				
Weight Watchers	☐ Yes ☐ No				
OptiFast	☐ Yes ☐ No				
Medi Fast	☐ Yes ☐ No				
Fen/Phen/Redux	☐ Yes ☐ No				
Meridia	☐ Yes ☐ No				
Lindora	☐ Yes ☐ No				
T.O.P.S.	☐ Yes ☐ No				
O.A.	☐ Yes ☐ No				
Acupuncture	☐ Yes ☐ No				
Metabolife	☐ Yes ☐ No				
Atkins Diet	☐ Yes ☐ No				
Pritikin Diet	☐ Yes ☐ No				

List any physician-supervised and documented weight loss attempts: _____

List any other diets and/or weight loss methods you've tried: _____

FOR OFFICE USE: Nutritional Guidelines

Reviewed:

- ☐Pouch size/small portion
- ☐Protein requirements/supplements
- ☐Water intake
- ☐Dumping syndrome
- ☐Alcohol sensitivity
- ☐Vitamin requirements
- ☐Importance of lifelong follow-ups

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

1- like very much 2 – like 3 – want occasionally 4 - don't care

_____Soda/Soft drinks _____French fries _____Chips/snacks

_____Steaks/chops _____Candy _____Potatoes

_____Chocolate _____Pasta _____Cookies

_____Pizza _____Cakes/pies _____Salad dressings

_____Fried foods

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease ☐ Yes ☐ No
   If Yes: ♦Year Diagnosed_____
   Do you have, or have you had:
   - ☐ Angina _____
   - ☐ M.I. (myocardial infarction) _____
   - ☐ CABG (coronary artery bypass graft) _____
   - ☐ Abnormal EKG _____
   - ☐ Stress test to rule out cardiac problems _____
   - ☐ Palpitations _____

2. High Cholesterol ☐ Yes ☐ No
   High Triglycerides ☐ Yes ☐ No
   If Yes: ♦Year Diagnosed: _____
   ♦List medications: _____

3. High Blood Pressure ☐ Yes ☐ No
   If Yes: ♦Year Diagnosed:_____
   ♦List medications:_____

4. Diabetes ☐ Yes ☐ No
   If Yes: ♦Year Diagnosed:_____
   ♦Gestational (pregnancy): ☐ Yes ☐ No
   ♦Neuropathy: ☐ Yes ☐ No
   ♦Treated with: ☐ Diet
   ☐ Medication (list) _____
   ♦Last fasting blood sugar:_____ How often checked: _____

5. Asthma ☐ Yes ☐ No
   If Yes: ♦Year Diagnosed: _____

♦ER visits/last 2 yrs: _____

♦Hospitalizations in last 2 years: _____

♦Steroids in last 2 years: ☐ Yes ☐ No

♦ Use inhaler: ☐ Yes ☐ No

6. Shortness of breath ☐ Yes ☐ No

If Yes, : ♦Can walk _____blocks

♦Stairs: _____ flights

7. Trouble Sleeping? ☐ Yes ☐ No

♦Morning headaches ☐ Yes ☐ No

♦Daytime drowsiness ☐ Yes ☐ No

♦Restless sleep ☐ Yes ☐ No

♦Snoring ☐ Yes ☐ No

♦Awakenings at night ☐ Yes ☐ No

♦Observed apneas ☐ Yes ☐ No

Office Use: sleep study ordered by _____

8. Sleep Apnea Syndrome ☐ Yes ☐ No

If Yes: ♦Year Diagnosed: _____

♦Last sleep study: _____ month/year

♦CPAP used: ☐ Yes ☐ No

9. Heartburn/esophagitis/hiatus hernia? ☐ Yes ☐ No

If Yes: ♦Year Diagnosed: _____

♦Upper GI series? ☐ Yes ☐ No

♦Endoscopy? ☐ Yes ☐ No

♦Medications: _____

♦Frequency of use:_____

10. Belching up acid or sour fluid ☐ Yes ☐ No

11. Coughing or choking at night ☐ Yes ☐ No

Office Use: ☐ *UGI/endoscopy*

12. Gallbladder disease ☐ Yes ☐ No

If Yes: How was it Diagnosed? ☐Ultrasound ☐ Physical Exam ☐ Other

Was gallbladder removed? ☐ Yes ☐ No

13. Leakage of urine with laughing/coughing/sneezing ☐ Yes ☐ No

If Yes: ♦Wear pads frequently? ☐ Yes ☐ No

14. Low back strain/pain/sciatica? ☐ Yes ☐ No (*Please circle all that apply)*

If Yes: ♦Seen by Chiropractor? ☐ Yes ☐ No

♦Orthopedic Surgeon? ☐ Yes ☐ No

♦Seen by Family Doctor? ☐ Yes ☐ No

♦Medications taken: _____

15. Pain in hips/knees/ankles/feet? ☐ Yes ☐ No (*Please circle all that apply)*

If Yes: ♦Seen by Chiropractor? ☐ Yes ☐ No

♦Orthopedic Surgeon? ☐ Yes ☐ No

♦Seen by Family Doctor?☐ Yes ☐ No

♦Medications taken_____

16. Weight related injuries and trauma:_____

_____

17. Venous Stasis Disease? ☐ Yes ☐ No

If Yes: ♦Do you have Edema? ☐ Yes ☐ No

♦Scaly & Thick Skin? ☐ Yes ☐ No

♦Leg Ulcers? ☐ Yes ☐ No

18. Gout? ☐ Yes ☐ No

If Yes: ♦Gouty Arthritis? ☐ Yes ☐ No

Medications taken _____

19. Bra size (females only): _____

Skin depressions from bra straps? ☐ Yes ☐ No

Do you have shoulder pain? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you experienced:

☐Measles	☐Mumps	☐Chickenpox	☐Obesity
☐Rheumatic fever	☐Heart murmur	☐Asthma	☐Tonsillectomy

Female Patients:

Pregnancy #1 Year_____ Weight at start_____ Weight at delivery_____

Pregnancy #2 Year_____ Weight at start_____ Weight at delivery_____

Pregnancy #3 Year_____ Weight at start_____ Weight at delivery_____

Pregnancy #4 Year_____ Weight at start_____ Weight at delivery_____

Number of pregnancies:_____ Age at first period: _____

Number of live births:_____ Date of last period: _____

Miscarriages/abortions:_____

Obstetric complications:_____

Last Mammogram date:_____

Last PAP smear date:_____

Do you presently use:

Birth control pills ☐ Yes ☐ No List type: _____

Estrogens ☐ Yes ☐ No List type: _____

Other contraceptive methods:_____

Serious Illnesses:

Have you had (check all that apply):

☐Hepatitis ☐Blood Transfusion ☐AIDS/HIV Exposure

☐Colitis ☐Kidney Disease ☐Bleeding Abnormality

☐Colonoscopy (Date) _____

☐Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness Date Treatment

_____

_____

_____

_____

_____

Major Surgery Date

_____

_____

_____

_____

_____

_____

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list medication and reaction:

_____

_____

_____

Allergic to:

Surgical tape ☐ Yes ☐ No Latex ☐ Yes ☐ No Iodine ☐ Yes ☐ No

Any other allergies? ☐ Yes ☐ No If yes, please list all other allergies:

_____

_____

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco? ☐ Yes ☐ No Frequency:_____

- Are you willing to quit? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Frequency: _____

FAMILY HISTORY

Family Member	Living?	Age/Age at Death	Illnesses/Cause of death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Fraternal Grandmother			
Fraternal Grandfather			
Sibling:			
Sibling:			
Sibling:			
Sibling:			

Please indicate if there is a family history of:

☐Obesity

☐Diabetes

☐High Blood Pressure

☐Heart Disease

☐High Blood Cholesterol

☐Lung disease, Asthma or Emphysema

☐Kidney Disease

☐Bleeding tendency or Blood Disorder

☐Breast Cancer

☐Colon Cancer

Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address	Telephone
Primary Care Physician	_____		
Internist	_____		
Gynecologist	_____		
Orthopedist	_____		
Psychiatrist	_____		
Psychologist	_____		
Endocrinologist	_____		
Other	_____		

SYSTEM REVIEW

*Please select **all** symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.*

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze

- ♦Men: discharge from penis – loss of erection – painful erection
- ♦Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – x-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

By signing here I verify that I have completed this form to the best of my knowledge:

Signature: _____ Date _____

Print Name:_____