Medical History Questionnaire for Bariatric/ Wt Management

Name ____ Today's date __________________

Date of Birth ________ Age_____ Sex: ___M ___ F **Current Height: _______ Weight: ________

Allergies:

Please list all allergies including foods, drugs, medications, tape, latex or history of asthma and hay fever:

____

Current Medications:

Please list all drugs, over-the-counter medications, or herbal remedies that you are currently taking.

Include dose and frequency for each entry (If more space is required please attach a separate page):

_______________________________________ ____

_______________________________________ ____

_______________________________________ ____

_______________________________________ ____

Obesity Related Medical History:

Do you have, or have you had, any of the following illnesses or symptoms. Check all that apply:

[ ] sleep apnea [ ] morning headache [ ] excess snoring [ ] wake up short of breath

[ ] esophageal reflux [ ] heartburn [ ] hiatal hernia [ ] chronic skin infections

[ ] diabetes [ ] high blood pressure [ ] heart disease

[ ] arthritis [ ] high cholesterol [ ] blood clots in legs or lungs

[ ] depression [ ] asthma [ ] urine incontinence

[ ] sciatica [ ] hernia [ ] irregular menses

Please list any other medical conditions and hospitalizations, past and current:

____

____

____

Past Surgical History:

Please list all surgical procedures and/or operations including dates:

____

____

____

____

Social history:

Please list your occupation: ____

How many children do you have: _________________ Ages:___________________________

Do you smoke tobacco? ______ If yes, number of packs per day: _____ Years of use: ______

Alcohol use: __ none __ few drinks per day __ few drinks per month __ few drinks per

Family History:

Do any congenital diseases run in your family, such as bleeding, clotting, gastro-intestinal disease, or other?

____

____

____

Please describe your family influences and/or support network as it pertains to your weight and eating habits.

____

____

Weight History

At what age did you become obese? _____________ What was your highest adult weight? ___________

What is your desired weight ___________________ Have you ever had weight loss surgery? ___________

Weight Loss Programs, Diets and/or Medications: Please check all boxes that apply:

[ ] Weight watchers [ ] jenny Craig [ ] Nutri system [ ] Diet Center [ ] Atkins

[ ] Weight Mngt [ ] Cambridge [ ] Slimfast [ ] SouthBeach [ ] Optifast

[ ] Medifast [ ] Xenical [ ]Meridia [ ] Phentermine [ ] Phen-fen

[ ] Redux

Please list any additional programs, diets, medications, and herbal remedies that you have tried:

____

Please describe your most recent program, diet, or medication. Be sure to include weight loss and regained and your thoughts about it:

____

What has been your most successful diet or program or medication, and why? ________________

____

What role does emotion play in your eating? _______________________________________

Do you tend to snack through the day? _______________________________________

Do you have trouble feeling full after eating? _______________________________________

Do you tend to eat late at night? _______________________________________

Do you think you eat portions that are too large? _______________________________________

Do you crave sweets such as milkshakes, smoothies, candy? ____________________________

What role does physical activity and exercise play in your life? ______________________________

____

____

Emotional Eating:

1. Do you eat more than you would like to when you have negative feelings such as stress, worry, anxiety, depression, anger, or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

2. Do you have trouble controlling your eating when you have positive feelings – do you celebrate feeling good by eating?

1 2 3 4 5

Never Rarely Occasionally Frequently Always

3. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you would like?

1 2 3 4 5

Never Rarely Occasionally Frequently Always

Goals and Attitudes:

1. Put an X on the line to show how important it is for you to make lifestyle changes:

…………………………………………………………………………………………

0 5 10

Not important Somewhat important Very important

2. Put an X on the line to show how ready you are to make lifestyle changes:

…………………………………………………………………………………………

0 5 10

Not ready Somewhat ready Very ready

3. Put an X on the line to show how confident you are that you can make lifestyle changes.

…………………………………………………………………………………………

0 5 10

Not confident Somewhat confident Very confident

4. What lifestyle changes would you be willing to make today?________________________________
____

5. How much time would you be willing to spend each day on making lifestyle changes? ___________

____

6. What things might make it hard for you to make lifestyle changes? ___________________________

____

7. Put an X on the line to show your current level of stress:

……………………………………………………………………………………….

0 5 10

Very relaxed Managing OK Very stressed

8. What are the main stressors in your life (i.e. work, marriage, family, boredom)? __________________

____

9. What strategies do you use to address these stressors? ____________________________________

____

Obstructive Sleep Apnea Screening Questionnaire:

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

___ Yes ___ No

2. Do you often feel tired, fatigued, or sleepy during the daytime?

___ Yes ___ No

3. Has anyone observed you stop breathing during your sleep?

___ Yes ___ No

4. Do you have or are you being treated for high blood pressure?

___ Yes ___ No

5. Is your BMI more than 35 kg/m2

? (can be answered by physician)

___ Yes ___ No

6. Is your age greater than 50 years old?

___ Yes ___ No

7. Is your neck circumference greater than 17in (male) or 16in (female)?

___ Yes ___ No