Medical, Gastro-Intestinal, Social Lifestyle Information Questionnaire TODAY'S DATE: / /

PATIENT NAME: **DOB:**

Gender: ☐ M / ☐ F Age: _____

Employment- (☐ PT / ☐FT) ☐Unemployed / ☐Retired / ☐Disabled / Occupation: _____

Reason for visit: _____

Race: PLEASE CHECK-OFF

CAUCASIAN	☐	HISPANIC	☐
AFRICAN AMERICAN	☐	ASIAN	☐
NATIVE AMERICAN	☐	OTHER	☐
MIDDLE EASTERN	☐	WISH NOT TO ANSWER	☐

Primary Care Physician: _____

Phone #: _____

***** WEIGHT HISTORY**

Have you been overweight since Childhood? ☐ Yes/ ☐ No

How many years have you been overweight? _____, at least 100 lbs overweight? _____

Maximum Weight? _____ When? _____ / **Minimum** Weight? _____, When? _____

Can you identify any changes that occurred which might have influenced your weight?

(ex. Pregnancy, medications, stress …) _____

WEIGHT LOSS METHOD/PROGRAM (WITHIN LAST 5yrs.)	**DATES: FROM- TO**	**WEIGHT LOSS/ GAIN**	**COMMENTS:**
Physician/ Dietitian Supervised		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Self-Imposed Dieting: Low fat, Soups, Juices, Describe:		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Organized Prgm: Circle Weight Watchers/ Jenny Craig / LA Weight Loss		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Exercise/Personal Trainers		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Medifast/Optifast		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Herbalife/Metabolife		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Atkins (low carb. diet)		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
High Protein Liquid Diet/Shakes		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Prescription Medications: Circle Adipex/Redux/Phentermine/Xenical/Meridia		☐ Loss ____ lbs. ☐ Gain ____ lbs.	
Other: Describe		☐ Loss ____ lbs. ☐ Gain ____ lbs.	

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*****Please list all past surgeries (description) :** **Year:**

*****Are you aware of any problems with anesthesia? ☐ YES / ☐ NO If yes, please explain below:**

_____

Any previous problems with insertion of breathing tube for surgery? ☐ YES / ☐ NO

Have you taken any steroids within the last six (6) months? ☐ YES / ☐ NO- Explain: _____

Medication Allergies	**Reaction**

Medical Allergies: _____ **Latex (Gloves, Balloons, etc.)** _____ **Surgical Tape**

I have **NO** medication **allergies** ☐ check Initials: _____

Family Medical History:

Medical Condition	**Family Member**	**Medical Condition**	**Family Member**
Diabetes Mellitus		Alcoholism	
High Blood Pressure		Thyroid Disorder	
High Cholesterol		Cancer	
Obesity		Blood Disorder	
Stroke		Kidney Disease	
Heart Disease		Lung Disease	
Depression		Other (include family member):	

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*****Patient: Please list <u>all of your current</u> medications and vitamins/supplements**

Medication Name	**Dose/Frequency**	**Reason**

PHYSICIAN NOTES:

Medical History- Have you, the patient, been diagnosed with any of the following:

DISEASE	**YES**	**NO**	**DISEASE**	**YES**	**NO**
High Cholesterol	☐	☐	High Triglycerides	☐	☐
High Blood Pressure	☐	☐	Heart Disease	☐	☐
Chest Pain	☐	☐	Heart Attack	☐	☐
Irregular Heart Rate	☐	☐	Murmur	☐	☐
Congestive Heart Failure	☐	☐	Mitral Valve Prolapse	☐	☐
Have you ever had a Stress Test?	☐	☐	Cardiac Catheterization (cath) ?	☐	☐
Diabetes- Type (1)	☐	☐	Diabetes- Type (2)	☐	☐
Thyroid Problems	☐	☐	COPD	☐	☐
Obstructive Sleep Apnea Year Tested:____ _____	☐	☐	If yes, do you use a CPAP machine?	☐	☐
Bronchitis	☐	☐	Daytime Fatigue	☐	☐
Snoring	☐	☐	Emphysema	☐	☐
Shortness of Breath with exertion	☐	☐	Shortness of Breath at rest?	☐	☐
Have you ever had a chest X-Ray? Year Tested: _____	☐	☐	Difficulty Urinating	☐	☐
Stress Incontinence	☐	☐	Blood in Urine	☐	☐

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DISEASE	YES	NO	DISEASE	YES	NO
Kidney Failure	☐	☐	Bladder Infections	☐	☐
Infertility	☐	☐	Kidney Infections	☐	☐
Gender Reassignment	☐	☐	Kidney Stones	☐	☐
Sexually Transmitted Disease	☐	☐	HIV/ AIDS	☐	☐
History Of Cancer	☐	☐	Cancer Type:		
Anemia	☐	☐	Bleeding Problems	☐	☐
Sickle Cell	☐	☐	Bruise Easily	☐	☐
Leukemia/Lymphoma	☐	☐	Moles, recent changes	☐	☐
Rashes	☐	☐	Leg Swelling	☐	☐
Joint Pain	☐	☐	Blood Clot	☐	☐
Arthritis	☐	☐	Varicose Veins	☐	☐
Chronic Back Pain	☐	☐	Hip Pain	☐	☐
Knee Pain	☐	☐	Ankle Pain/ Foot Pain	☐	☐
Chronic Edema	☐	☐	Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐	Chronic Venous Insufficiency	☐	☐
Osteoporosis	☐	☐	Gout	☐	☐
Unplanned Weight Loss	☐	☐	Chills	☐	☐
Chronic Sinusitis	☐	☐	Sinus Headache	☐	☐
Hearing loss/ problems	☐	☐	Neuropathy	☐	☐
Dizziness	☐	☐	Alzheimer's Disease	☐	☐
Tension Headaches/ Chronic Headaches/ Migraines	☐	☐	Stroke	☐	☐
Seizures	☐	☐	Tremors	☐	☐
Glaucoma	☐	☐	Multiple Sclerosis	☐	☐
Fainting Spells	☐	☐	Numbness	☐	☐
Weakness/Paralysis	☐	☐	Other:		
Physical Problems Interfering with Lifestyle	☐	☐	Other:		

PHYSICIAN NOTES:

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GASTRO-INTESTINAL HISTORY

Heartburn	Irritable Bowel Syndrome (IBS)
Acid reflux/GERD	Chron's Disease
Hoarseness	Diarrhea
Sore Throat	Black Stools (Bowels)
Laryngitis	Blood in stools (bright red blood)
Throat Clearing	Constipation
Difficulty Swallowing	Diverticulitis
Feeling of something in throat	Diverticulosis
Burping/Belching	Teeth Sensitivity
Bloating	History of Barretts Esophagus
Regurgitation	Colon Polyps
Vomiting	Difficulty Sleeping Secondary to GI symptoms
Vomiting with Blood	Nocturnal Chocking
History of Ulcers	Nocturnal Drooling

PHYSICIAN NOTES:

SOCIAL HISTORY

Status: ☐Single/☐ Married/ ☐Separated/☐Divorced/ ☐Widowed -- Previously divorced: ☐ Yes/☐ No

Do you use tobacco: ☐Yes/ ☐No - Currently smoke? _____Packs/day for _____ years.

Willing to quit? ☐Yes /☐ No --Quit smoking ____ yrs. ago but previously, _____ packs/day for _____ yrs.

Do you drink alcohol? ☐ Yes / ☐ No --- ☐ Daily / ☐ Weekly / ☐ Monthly / ☐ Socially

Do you use recreational drugs? ☐ Yes / ☐ No --- Are you currently exercising regularly? ☐ Yes / ☐ No

If exercising, what type of activity and how often? _____

EMOTIONAL WELL BEING

Have you ever seen a Psychiatrist/ Psychologist? ☐ Yes / ☐ No Currently? ☐ Yes / ☐ No

Reason: ☐ Dual Personality ☐ Schizophrenia ☐ Nervous Breakdown ☐ Depression

☐ Eating Disorder ☐ Substance Abuse ☐ Anxiety Attacks

PATIENT NAME: **DOB:**

CONTINUED:

Is there any current depression? ☐ Yes / ☐ No ----Have you ever been admitted to a psychiatrist institution? ☐ Yes / ☐ No

If yes, when? _____ For how long? _____

Reason: _____

Have you ever been abused? ☐ Physically / ☐ Sexually/ ☐ Emotionally-- Received medical treatment and/or counseling? ☐ Yes / ☐ No

Have you ever had an addiction? ☐ Yes / ☐ No --- ☐ Alcohol /☐ Drugs / ☐ Other: _____ _____

If yes, have you received treatment? ☐ Yes / ☐ No Is the addiction current? ☐ Yes / ☐ No

Have you considered suicide? ☐ Yes / ☐ No Do these feelings continue? ☐ Yes / ☐ No

Have you ever attempted suicide? ☐ Yes / ☐ No --- *If yes*, when? _____

Have you ever uncontrollably binged on a large amount of food at one time? ☐ Yes / ☐ No

Have you ever intentionally vomited after eating in order to control weight? ☐ Yes / ☐ No

Have you ever used laxatives in order to control weight? ☐ Yes / ☐ No

Have you ever intentionally starved yourself in order to lose weight? ☐ Yes / ☐ No

Have you ever hidden foods/food intake from others in your home? ☐ Yes / ☐ No

Have you ever been medically diagnosed with an eating disorder? ☐ Yes / ☐ No When? _____

☐ Anorexia / ☐ Bulimia / ☐ Binge Eating/ ☐ Other: _____ _____

Do you feel you have an excess amount of daily stress? ☐ Yes / ☐ No

If yes, from where? (Ex. Work, finances, family, etc)? _____

Do you feel you have a helpful support system around you? ☐ Yes / ☐ No --Who? _____

Please describe what you hope to accomplish and how you believe your life will change by losing weight:

_____

_____

All of the information that I have submitted is accurate to the best of my knowledge. I understand that giving false or incomplete information can adversely affect my treatment and outcome. I accept any responsibility for such omissions and inaccuracies.

_____ _____

Print Name **Date**

_____

Signature