INTEGRIS
Weight Loss Center

Patient Health History Questionnaire

The information requested in this questionnaire is very important in order to give you the best care, and to obtain your insurance approval. Please be thorough and answer questions completely.
Blue or black ink only, please.

Name:		Date of Birth
Age:	Gender: male ☐ female ☐	Occupation: (If retired, what did you do?)
Height:	Weight:	Phone number:

Primary Care Physician: _____

Primary Pharmacy: _____

WEIGHT HISTORY

What has been your heaviest weight?_____lbs.

What is the least you have ever weighed as an adult? _____lbs When? _____

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

_____

_____

_____

Who will support you during and after your surgical weight loss procedure? _____

_____

DIETARY HISTORY

Approximate age you first seriously started dieting: _____

Please identify the diets and diet programs you have tried, if any:						
Program	**Yes**	**No**	**Dates**	**Duration**	**MD supervised**	**Max Loss**
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Atkins Diet						
O.A.						
Metabolife						
Self Created Diet						
Other						

Eating Habits: ☐ Sweets ☐ Salty snacks ☐ Portion Control ☐ Skipping meals

MEDICAL HISTORY

Medical Condition	Current	Past	Medical Condition	Current	Past
AIDS			Hemorrhoids		
Alcohol Abuse			Hepatitis A		
Allergies (Seasonal)			Hepatitis B		
Angina			Hepatitis C		
Anxiety			Hernia		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Back Pain			High Triglycerides		
Bleeding Abnormality			Incontinence		
Blood Clots			Infertility		
Bronchitis			Irreguar Menses/Periods		
Cancer			Irritable Bowel Syndrome		
Chronic Cough			Kidney Disease		
Colitis			Kidney Stones		
Crohn's Disease			Liver Diease		
Deep Vein Thrombosis			Lung Disease		
Depression			Mental Illness		
Diabetes I			MI/Heart Attack		
Diabetes II			Neuropathy		
Diverticulitis			Plantar Fasciitis		
Emphysema			Polycystic Ovarian Syndrome		
Endometriosis			Pulmonary Embolus		
Epilepsy			Rheumatic Fever		
Fatty Liver			Shortness of breath		
Gallbladder Disease			Sleep Apnea		
Gestational Diabetes			Stomach Ulcer		
Gout			Stroke		
Heart Disease			Thyroid Problems		
Heart Palpitations			Venous Stasis Disease		
Heart Murmur					

SURGICAL HISTORY

Type of Surgery	Date of Surgery
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

FAMILY HISTORY

Additional Family History: (check the ones that apply)

Disease/Problem	Relationship to patient
☐ Obesity	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____
☐ Heart Disease	_____
☐ High Cholesterol	_____
☐ Stroke	_____
☐ Gallbladder Problems	_____
☐ Polycystic Ovary Syndrome	_____
☐ Lung disease, Asthma, Emphysema	_____
☐ Kidney Disease	_____
☐ Bleeding tendency/Blood Disorder	_____
☐ Breast Cancer	_____
☐ Colon Cancer	_____
☐ Liver Disease	_____
☐ Thyroid Disease	_____
☐ Stomach Cancer	_____
☐ Esophageal Cancer	_____
☐ Pancreatic Cancer	_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed/Widower

Do you use tobacco?

☐ Never Smoked

☐ Current Smoker — If yes, are you willing to quit? ☐ Yes ☐ No

Age Started _____

Packs/day _____

☐ Former Smoker

Year Quit: _____

Packs/day: _____

Smokeless Tobacco ☐ Yes ☐ No — If yes, what product: _____ When did you start: _____

Do you use alcohol? ☐ Yes ☐ No — If yes, how often: _____ Type of alcohol: _____

Do you currently use recreational drugs? ☐ Yes ☐ No — If no, have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever been treated for narcotic dependency? ☑ Yes ☐ No

REVIEW OF SYSTEMS

Please check all symptoms you are currently experiencing, or have experienced in the past year.

HEAD, EYE, EAR, NOSE & THROAT:

- ☐ nasal discharge
- ☐ hay fever
- ☐ sinus trouble
- ☐ earache
- ☐ headache
- ☐ blurry vision
- ☐ double vision
- ☐ vision halos
- ☐ loss of night vision
- ☐ ringing in ears
- ☐ discharge from ears
- ☐ loss of hearing
- ☐ dizziness
- ☐ vertigo
- ☐ loss of balance
- ☐ sore throat
- ☐ lump in throat
- ☐ trouble swallowing
- ☐ pain with swallowing
- ☐ hoarseness
- ☐ NONE OF THE ABOVE

RESPIRATORY:

- ☐ asthma or wheezing
- ☐ emphysema
- ☐ bronchitis
- ☐ chronic or frequent cough
- ☐ spitting/coughing up blood
- ☐ use of two pillows
- ☐ out of breath with exertion
- ☐ shortness of breath
- ☐ wake up at night short of breath
- ☐ NONE OF THE ABOVE

CARDIOVASCULAR:

- ☐ palpitations
- ☐ pounding heart
- ☐ skipping heartbeat
- ☐ chest pain
- ☐ history of heart attack
- ☐ abnormal EKG/ECG
- ☐ high blood pressure
- ☐ pain in legs
- ☐ NONE OF THE ABOVE

GASTROINTESTINAL:

- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ choking on food
- ☐ food sticking in chest
- ☐ burning in stomach
- ☐ diarrhea
- ☐ constipation
- ☐ pain with bowel movement
- ☐ blood in stools
- ☐ hemorrhoids
- ☐ fissures
- ☐ gassiness
- ☐ frequent bowel movements
- ☐ NONE OF THE ABOVE

GENITOURINARY:

- ☐ pain with urination
- ☐ changes in urinary habits
- ☐ small urine stream
- ☐ blood in urine
- ☐ kidney stones
- ☐ bladder stones
- ☐ kidney failure
- ☐ nephritis
- ☐ urinary tract infection
- ☐ frequent urination
- ☐ getting up at night to urinate
- ☐ NONE OF THE ABOVE

ENDOCRINE:

- ☐ hypothyroid
- ☐ hyperthyroid
- ☐ goiter
- ☐ diabetes
- ☐ adrenal gland tumor
- ☐ frequent flushing
- ☐ frequent heavy sweating
- ☐ NONE OF THE ABOVE

MUSCULOSKELETAL:

- ☐ pain in joints
- ☐ swelling of joints
- ☐ broken bones
- ☐ sprains
- ☐ herniated disc
- ☐ limited joint motion
- ☐ NONE OF THE ABOVE

NEUROLOGICAL:

- ☐ numbness
- ☐ tingling
- ☐ weakness of any muscles
- ☐ twitching of muscles
- ☐ fainting
- ☐ convulsions
- ☐ NONE OF THE ABOVE

PSYCHOLOGICAL:

- ☐ nervousness
- ☐ anxiety
- ☐ depression
- ☐ thoughts of suicide
- ☐ suicide attempts
- ☐ hospitalization for emotional problem
- ☐ psychiatric treatment
- ☐ psychological counseling
- ☐ memory problems
- ☐ mood changes
- ☐ NONE OF THE ABOVE

REPRODUCTIVE: (females)

- ☐ premenstrual mood swings
- ☐ taking birth control
- ☐ hormone replacement therapy
- ☐ history of ovarian cyst(s)
- ☐ menopause
- ☐ abnormal pap smear
- ☐ abnormal mammogram
- ☐ NONE OF THE ABOVE

MEDICATIONS, PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL

Medication	Strength	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

MEDICATION ALLERGIES

Name of Medication			Type of Reaction			
1)						
2)						
3)						
4)						
5)						

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to Iodine? ☐ Yes ☐ No

Are you allergic to surgical tape? ☐ Yes ☐ No

Present or past history of eating disorders?

Anorexia- fear of weight gain leading to malnutrition and ususally excessive weight loss ☐ Yes ☐ No

Bulemia- overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise ☐ Yes ☐ No

Binge Eating Disorder- consuming a large quantity of food in a short period of time ☐ Yes ☐ No

Night Eating Disorder- eating very late at night, waking up in the middle of the night to eat. ☐ Yes ☐ No

If you answered YES to any of the above:

Have you been in treatment for the disorder? ☐ Yes ☐ No

Do you believe you still have problems with the disorder? ☐ Yes ☐ No

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

_____

_____

Who does the grocery shopping at home? _____

Who does the cooking at home? _____

How many meals do you eat per day? _____

How many meals do you eat outside the home, **per week**? _____

Do you like/prefer carbohydrates (starches and sweets) over other foods? _____

ACTIVITY/EXERCISE

To what extent do you enjoy activity/exercise? (check the ones that apply one)

Not at all ☐ Slightly ☐ Moderately ☐ Greatly ☐

Area/Methods Utilized: (check the ones that apply)

☐ Health Club ☐ Home ☐ Outdoors ☐ Pool ☐ Walking ☐ Jogging
☐ Other: _____

Current method of exercise: (check the ones that apply)

☐ No current method of exercise

☐ Resistance/Weight Training
Duration per day: _____

☐ Aerobic/Endurance/Cardio Training
Frequency per week: _____

SLEEP HISTORY

Have you been diagnosed with sleep apnea syndrome?

☐ Yes
☐ No

If yes, year diagnosed: _____
Date of last sleep study? _____
Do you use a CPAP? _____
If yes, what is your CPAP setting? _____

Do you have or have you ever had: (check the ones that apply)

☐ morning headaches ☐ awakening at night
☐ restless sleep ☐ trouble sleeping

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☑ Yes ☐ No

Do you often feel tired, fatigued, or sleepy during the day? ☐ Yes ☐ No

Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

OFFICE USE ONLY	Yes	No
1. Snoring		
2. Tired		
3. Observed Apnea		
4. HTN/Tx		
5. BMI/35		
6. Age/50		
7. Neck Circum. 16"		
8. Gender/Male		

The above information is true and correct to the best of my knowledge. I understand that the accuracy of the information provided is important, and may affect my medical outcome.

_____ _____
Printed name Date

_____
Signature