

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 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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Polycystic Ovarian Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Seizure/Convulsion |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Coagulation (bleeding or clotting) problem |

What kind: _____

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.

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Alcohol problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drug problems |
| <input type="checkbox"/> Life stressors (divorce, death in family, etc.) | <input type="checkbox"/> Physical or sexual abuse |
| <input type="checkbox"/> Other: | |

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

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?

	Yes	No	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.