PATIENT HEALTH 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***. Blue or black ink only, please.

Name		Date
Age	Gender Male Female	Occupation (If retired, what did you do?)
Actual Body Weight		
Height		
Referral Source		

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:

_____

_____

_____

_____

_____

_____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Yes	No	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Atkins Diet						

Name	Date

Program	Yes	No	Dates	Duration	MD Supervised?	Max Loss
O. A.						
Metabolife						

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

_____

_____

_____

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

_____

_____

_____

DIETARY / EATING PATTERNS:

Who does the shopping at home? _____

Who does the cooking at home? _____

How many meals do you eat per day? _____

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

Do you like carbohydrates (starches and sweets) more than other foods? _____

ACTIVITY / EXERCISE:

To what extent do you enjoy activity/exercise? (circle one) Not at all Slightly Moderately Greatly

Area/Methods Utilized: Health Club Home Outdoors Pool Walking Jogging
Sports: _____

Method of Exercise:

Aerobic/Endurance Training: Y / N Resistance Training: Y / N

Frequency per week: _____ Duration per day: _____

Activity/Exercise in the past: Y / N What kinds of activity: _____

_____

Name	Date

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? ____ Yes ____ No
   - Neuropathy? ____ Yes ____ No
   - Controlled with: ____ Diet Oral Medication (list) _____
   - Last fasting blood sugar _____

5. Asthma? ____ Yes ____ No
   If Yes: - Year Diagnosed _____
   - ER visits/last 2 yrs. _____
   - Hospitalizations last 2 yrs. _____
   - Steroids last 2 yrs.? ____ Yes ____ No

6. Shortness of breath? ____ Yes ____ No
   If Yes: - Can walk _____ Blocks
   - Stairs _____ Flights

7. Trouble Sleeping? ____ Yes ____ No
   - Morning headaches? ____ Yes ____ No
   - Restless sleep? ____ Yes ____ No
   - Awakenings at night? ____ Yes ____ No
   - Daytime drowsiness? ____ Yes ____ No
   - Snoring? ____ Yes ____ No
   - Observed apneas? ____ Yes ____ No

Name	Date

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

12. Gallbladder disease? ____ Yes ____ No
    If Yes: - How was it diagnosed? ____ Ultrasound ____ GB 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
    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
    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: _____

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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: _____

Name	Date

19. Personal history of deep vein thrombosis (DVT), blood clots or pulmonary embolus? ____ Yes ____ No
    Family history? ____ Yes ____ No

PAST MEDICAL HISTORY

Please identify which of the following you have experienced:

____ Stroke	____ Obesity	____ Infertility	____ Polycystic Ovary Syndrome
____ Rheumatic fever	____ Heart murmur	____ Asthma	____ Tonsillectomy
____ Fatigue	____ Hepatitis	____ Blood Transfusion	____ AIDS/HIV Exposure
____ Colitis	____ Kidney Disease	____ Thyroid Problems	____ Bleeding Abnormality

Female Patients:

Number of pregnancies: _____ Age at first period: _____
Number of live births: _____ Date of last period: _____
Miscarriages/abortions: _____
Obstetric complications: _____
Last Pap Smear: _____ Last Mammogram: _____

Do you presently use:

Birth control pills? ____ Yes ____ No List type: _____
Estrogens? ____ Yes ____ No List type: _____
Other Contraceptive method: _____

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

Surgery History	Date

Allergies:

Allergic to any medications? ____ Yes ____ No If Yes, please list medication and reaction:

_____

_____

Allergic to: Surgical tape? ____ Yes ____ No Other Allergies:
Latex? ____ Yes ____ No _____
Iodine? ____ Yes ____ No _____

Name	Date

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

Have you ever used tobacco? ____ Yes ____ No Frequency: _____

When did you quit? _____ _____

Do you use alcohol? ____ Yes ____ No Frequency:

Have you ever been treated for narcotic dependency? ____ Yes ____ No _____

Do you currently utilize recreational drugs? ____ Yes ____ No _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

Name	Date

Please indicate if there is a family history of:

____ Obesity
____ Diabetes
____ High Blood Pressure
____ Heart Disease
____ High Blood Cholesterol
____ Stroke
____ Gallbladder Problems
____ Polycystic ovary Syndrome
____ Lung disease, Asthma or Emphysema
____ Kidney Disease
____ Bleeding tendency or Blood Disorder (blood clot, DVT or emboli)
____ Breast Cancer
____ Colon Cancer
____ Liver Disease
____ Thyroid Disease

Personal Physicians:

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

	Name	Address/Location	Phone Number	Fax Number
Primary Care Physician		**Must be completed**	***Must be completed***	***Must be completed***
Cardiologist				
Pulmonologist				
Other				

SYSTEM REVIEW

Please circle 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: nasal discharge – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision –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 – *NONE OF THE ABOVE*.

2. RESPIRATORY: cough – wheezing – shortness of breath – use of two pillows – coughing up blood– out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis – *NONE OF THE ABOVE*.

Name	Date

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – heart attack (history of AMI) – heart murmur – abnormal electrocardiogram – high blood pressure – pain in legs while walking – cold feet – blue toes – *NONE OF THE ABOVE*.

4. 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 – irritable bowel syndrome – colitis – *NONE OF THE ABOVE*.

5. GENITOURINARY: pain with urination – changes in urinary habits - 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 – *NONE OF THE ABOVE*.

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating – *NONE OF THE ABOVE*.

7. MUSCULOSKELETAL: pain in joints – swelling of joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – herniated disk – sciatica – limited joint motion – *NONE OF THE ABOVE*.

8. NEUROLOGICAL: numbness – tingling – weakness of any muscles – twitching of muscles – fainting – convulsions –*NONE OF THE ABOVE*.

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling – memory problems – mood changes – *NONE OF THE ABOVE.*

10. REPRODUCTIVE (Females): premenstrual mood swings – inability to conceive –hormone replacement therapy – history of ovarian cysts – menopause – regular Pap smears – abnormal Pap smears –abnormal mammogram – *NONE OF THE ABOVE.*

How would you describe your general mood and emotions?

Name	Date

Present or past history of eating disorders?

____ Yes ___ No Anorexia (fear of weight gain leading to malnutrition and usually excessive weight loss)

____ Yes ___ No Bulimia (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)

If you have answered YES to any of the above:

____ Yes ___ No Have you been in treatment for the disorder?

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

What type of medication or treatment plans have you completed related to eating disorders?

_____

_____

_____

The above information is true and correct to the best of my belief. I understand that the accuracy of this information is important and may affect medical outcomes.

_____

Patient Name

_____

Date