BARRINGTON BARIATRIC CENTER

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~ The Path to a Healthier Lifestyle ~

Health History Questionnaire

This Health History Questionnaire is designed to help us understand your medical history and customize a surgical weight loss program especially for you.

Patient's Name:_____ **SSN#:** _____
Last Name First Name Middle Initial

Home Address:_____ **City/State/Zip:**_____

Date of Birth: _____ **Age:** _____ **Sex: M F**

Martial Status: Married ____ **Single** ____ **Divorced** ____ **Widowed**____

Home Phone: (_____**)** _____**Work Phone: (**_____**)** _____

Cell Phone: (_____**)** _____ **Best # to be reached during the day: Home Work Cell**

Email: _____

Occupation: _____

Current Weight: _____ **Height** _____

CHIEF COMPLIANT: What is the main reason for your visit today? Describe.

_____
_____

How did you first hear about BARRINGTON BARIATRIC CENTER (please circle all that apply)?
Friend Family Doctor TV Radio Newspaper Internet Other _____

Who (physician) requested your evaluation with us today? Please list name, phone #, address and specialty of this doctor.

Name: _____**MD or DO**

Which procedure are you interested in? Gastric Band Gastric Bypass Sleeve

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Physician Information: Please list all doctors that you have seen and are helping in your care:

Name: MD, DO, NP	Address	Phone	Specialty	Do you want us to send an update letter(s) to this MD about your involvement in our program?

Date of Last Annual Physical exam with your doctor: _____

History of Present Illness – Weight / Diet History

1. At what age did you start to become overweight? _____
2. What was your weight ranges between the ages of 15 and 20? Minimum ____ Maximum _____
3. What has been your weight during the past 5 years? Minimum ___ Maximum _____
4. What has been your weight during the past 1 year? Minimum _____ Maximum _____
5. What has been the maximum weight you have ever weighed? _____
6. Please circle how many times have you tried an unsupervised (those that you do on your own) diets in your life? Try to make an educated guess if you do not know the exact amount of times.

0 1-5 6-10 11-25 26-50 50-100 >100

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Please list all diet programs you have done in the past 5 years

Diet Program	Year and Duration (i.e. 3 month)	Total Weight Loss	Pounds gained	Documentation Available?
EXAMPLE DIET	***1996 – 6 months***	***10 pounds***	***16 pounds gained back***	***Yes***
Dietician				
Phen-Fen				
Redux				
Meridia				
Fasting				
Nutra Systems				
Jenny Craig				
Overeaters anonymous				
Seattle Sutton				
Metabolife				
Weight Watchers				
Optifast				
Atkins				
Slimfast				
Hypnosis				

Other Programs: (List Here)

_____

_____

_____

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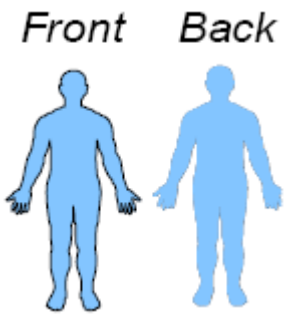
7. Where is most of your weight?



- **Abdomen** _____
- **Chest** _____
- **Legs** _____
- **Other** _____

8. On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem? 1 2 3 4 5 6 7 8 9 10

9. When did you feel your weight was a problem?
2 months ago 2 years ago 5 years ago More than 5 years ago

10. When relaxing, what makes you most comfortable?
Moving Around Standing Up Lying on your side Other

11. How long have you considered yourself overweight??
6 months 5 years As long as I can remember
Other_____

12. Is anything else occurring at the same time?
YES NO If yes, please explain.
Nausea Regurgitation Headaches
Other_____

13. Does your problem interfere with your normal functions?
Please Explain: _____

14. What is the most weight you have lost during any diet program? _____

15. How many meals do you consume per day? _____ How many snacks? _____

16. Do you prefer sweets over other types of food? Yes No
Other_____

17. Do you have any food allergies? Yes No If yes, please list_____
_____

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18. Do you: Over eat Over Indulge or binge eat?
(Over eating is when you plan to eat a normal amount and you overeat but not to the point of feeling like you may vomit. Over indulgence is when you plan to eat too much but not to the point of wanting to vomit. Binge eating is defined as eating a large amount of food during a short period of time, typically no more than 2 hours, **while feeling out of control to stop eating**.)

19. Do you purge (make yourself vomit after a meal)?
Yes No If yes, how often? _____

20. How many soft drinks do you consume per day? Diet_____ Regular_____

21. How many cups of coffee do you consume per day? ___cups of tea? ___cups

22. Do you add: sugar artificial sweeteners creamer

23. How much water do you drink per day? _____

Exercise History

24. Do you exercise routinely? Yes No

Frequency (how often) _____

Intensity: circle one light somewhat hard hard {heavy} very hard

Time (minutes) _____

Type (walk, bicycle, etc.) _____

How long have you been doing this program? _____

25. If you do not exercise, what is your primary limitation that makes exercise difficult?
_____ Lack of Time
_____ Lack of Motivation
_____ Lack of access to equipment
_____ Physical pain (please describe) _____
_____ Other (please describe) _____

26. What exercise equipment do you have available? Circle all that apply.

Treadmill Stationary Bike Rowing Machine Pool Elliptical Gazelle
Aerobics Videos Other: _____

Fitness Center Membership Yes No
Curves Membership Yes No

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27. How far can you walk without having difficulty? < 1 block <1/2 mile <1 mile >1 mile

When you go past this distance, what limits your ability to continue? _____

Please rank these in terms of severity (0→5) with zero being minimal and "5" being severe.

Shortness of breath_____
Chest pain _____
Fatigue or tired _____
Muscular pain in calf or thigh _____
Pain in joints (which ones) _____
Other _____

How many stairs can you climb without difficulty? _____

Psychological History

30. Have you seen a mental health professional such as a psychiatrist or psychologist for treatment in the last 2 years? Yes No

Have you been hospitalized for a psychiatric condition in the last 2 years? Yes No
If yes, please describe: _____

_____

31. In the past two years have you:

- Experienced severe anxiety or panic attacks? Yes No
- Experienced feelings of depression? Yes No
- Been on any medications for depression, anxiety, or other Psychological reasons? Yes No

If yes, please list those medications: _____

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OB-GYN History

32. If female, please answer the following questions.

- How many times have you been pregnant? _____
- How many live births? _____
- Do you have Polycystic Ovarian Syndrome? Yes or No
- After childbirth, has your weight: increased stayed the same decreased
- What type of birth control method do you use? _____
- If you are pre-menopausal, do you have any problems with your periods? (Note, if you are on birth control pills or shots to regulate your periods check yes) Yes No
- If yes, please circle: Heavy Painful Irregular
- Describe_____
- If you are post menopausal are you on hormone replacement therapy? Yes No
- Have you ever had problems with infertility? Yes No
- Please give the last date(Month/Year) had the following exams:
  Pelvic exam ___/_____ Breast exam ___/____
  Mammogram ___/____ Pap Smear ___/____

  If any were abnormal, please explain: _____

PLEASE CONTINUE TO NEXT PAGE

Physician use only: (Comments/Notes): Pages 2 – 7

_____

_____

# Answers	**Level of Service**
1 - 3	*1 or 2*
4+	*3 - 5*

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Past Medical, Family, Social History

Family History

1. What <u>percentage</u> of people on your mother's side of the family are overweight? _____%
2. What <u>percentage</u> of people on your father's side of the family are overweight? _____%
3. Does anyone in your **family** have any of the following illnesses:

Disease	Circle	Relationship	Notes
Diabetes	Yes No		
Thyroid	Yes No		
Adrenal	Yes No		
Heart	Yes No		
Hypertension	Yes No		
Abnormal Cholesterol/Triglycerides	Yes No		
Cancer	Yes No		
Bleeding or Clotting disorders	Yes No		
Respiratory or Tuberculosis	Yes No		
Other major diseases	Yes No		

Medications

Please list your current medications including: inhalers, birth control pills/shots, over-the-counter medications, vitamins, minerals and herbal supplements:

Name **Dosage** **How frequently do you take this medication in a day?**

_____

_____

_____

_____

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4. Do you have any Allergies? Yes No

Please list_____

5. Have you been on any kind of steroids in the last 12 months? Yes No

Please list _____

6. Do you consume (drink) alcohol? Yes No If yes, how often? _____

7. Do you smoke cigarettes? Yes No If yes, how many packs per day? _____

Surgical History

Type of Surgery	Date	Reason for Surgery

PLEASE CONTINUE TO NEXT PAGE

Physician use only: (Comments/Notes): Pages 8 – 9

_____

_____

# Answers	Level of Service
0	*1 or 2*
1 - 2	*3*
3	*4 or 5*

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Review of Systems

Please circle the appropriate response and answer all questions completely.

Constitutional Symptoms

Yes	No	Fever	Yes	No	Chills
Yes	No	Headache	Yes	No	Other

Eyes

Yes	No	Blurred Vision	Yes	No	Pain
Yes	No	Double Vision	Yes	No	Other

Ear/Nose/Throat/Mouth

Yes	No	Ear Infection	Yes	No	Sore Throat
Yes	No	Sinus Problems	Yes	No	Other

Respiratory

Yes	No	Wheezing	Yes	No	Frequent Cough
Yes	No	Other	Yes	No	Shortness of Breath

Gastrointestinal

Yes	No	Abdominal Pain	Yes	No	Nausea/Vomiting
Yes	No	Indigestion	Yes	No	Stomach or duodenal ulcer
Yes	No	Heartburn	Yes	No	Other

Genitourinary

Yes	No	Urine Retention	Yes	No	Painful Urination
Yes	No	Urinary Frequency	Yes	No	Problems leaking urine
Yes	No	Other	Yes	No	Problems with menstruating

Musculoskeletal

Yes	No	Joint Pain	Yes	No	Neck Pain
Yes	No	Back Pain	Yes	No	Other

Integumentary

Yes	No	Skin Rash	Yes	No	Persistent itching
Yes	No	Boils	Yes	No	Other

Neurological

Yes	No	Tremors	Yes	No	Dizzy Spells
Yes	No	Other	Yes	No	Numbness / Tingling
Yes	No	Other			

Endocrine

Yes	No	Excessive Thirst	Yes	No	Do you have Diabetes?
Yes	No	Tired / Sluggish	Yes	No	Too Hot / Too Cold
Yes	No	Other			

Cardiovascular

Yes	No	Chest Pains	Yes	No	High Blood Pressure
Yes	No	Varicose Veins	Yes	No	Swelling in Legs

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Yes No Ulcer or non-healing sores on your legs?
Yes No Ever seen a Cardiologist?
Yes No Had a heart attack or any other heart problems?
Yes No Other

Hematologic/Lymphatic
Yes No Swollen Glands Yes No Blood Clotting Problem
Yes No Other

Allergic/Immunologic
Yes No Hay Fever Yes No Drug Allergies
Yes No Other

Psychological
Yes No Are you generally satisfied with your life?
Yes No Do you feel severely depressed?
Yes No Have you considered suicide?
Yes No Other

Other Questions
Yes No Have you been diagnosed with: HIV AIDS Hepatitis B Hepatitis C
Yes No Do you snore?
Yes No Have you ever been told that you stop breathing when you sleep?
Yes No Have you ever fallen asleep at the wheel?
Yes No Do you have to take a nap every day?
Yes No Do you feel rested when you make up in the morning?
Yes No Do you wake up (from a deep sleep) choking or coughing?
Yes No Have you ever been told you have sleep apnea? Do you use c-pap or bi-pap?
Yes No Have you ever had surgery for weight loss? Surgeon name _____

Surgeon Name: _____ **Date:** _____

Reviewed
Surgeon Name: _____ Date: _____
Comments:

Surgeon Name: _____ Date: _____
Comments:

Surgeon Name: _____ Date: _____
Comments:

Surgeon Name: _____ Date: _____
Comments: