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Medical History Questionnaire

Please fill out this questionnaire completely. DO NOT LEAVE ANY QUESTIONS BLANK. If the question does not apply, please put "N/A."

Current Height: _____ Current Weight: _____ BMI: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: ___M / F_____

Phone: (cell) _____ (work) _____ (home) _____

Email: _____ Occupation: _____

Employer: _____ Full-time/Part-time: __FT / PT_

Insurance Co.: _____ Phone: _____

Policy # _____ Group # _____

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

2nd Insurance Co. _____ Phone # _____

Policy # _____ Group # _____

Primary Physician:_____Phone # _____

Address: _____

Other Physicians Seen Recently: _____

Circle procedure most interested in: Gastric Bypass | Gastric Sleeve | Management of Prev. Bariatric Surgery

Signature: _____ Date: _____

PLEASE READ: If you have health insurance, we strongly recommend that you call your insurance company in advance to determine coverage and/or exclusions for weight-loss surgery. If you do not have insurance coverage for weight-loss surgery, you may pay cash or you may secure your own financing (not available through Wilmington Health).

How many years have you been overweight? _____

Diet programs and supplements: Please indicate which of the following diets or programs you have previously attempted.

Program	Dates	Duration	MD supervised?	Pounds Lost
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutrisystem				
Atkins Diet				
Herbalife				
SlimFast				
Grapefruit Diet				
Liquid Diets				
Pritikin Diet				
Optifast				
T.O.P.S.				

List any other physician-supervised weight-loss attempts:

_____

_____

_____

_____

_____

_____

Weight-Loss Medication History: Please indicate if you have taken any of the following medications for the purpose of losing weight.

Medication:	Dates	Duration	MD supervised?	Pounds Lost
Sibutramine (Meridia)				
Phen-Fen				
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Dexfenfluramine (Redux)				
Xenical (Orlistat)				
Other Diet Medications:				

Non-Dietary Therapies: Please indicate if you have tried any of the following weight-loss therapies.

Therapy:	Dates	Duration	MD supervised?	Pounds Lost
Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

List any other weight-loss methods you have previously tried:

_____

_____

Previous Weight-Loss Surgery: Have you ever had surgery for the purpose of losing weight?

_____ No _____ Yes If yes, please answer info below:

Surgery Type	Date	Surgeon	Pounds Lost

Obesity-Related Medical History:

Do you have, or have you had, any of the following illnesses or symptoms?

Heart Disease	**Yes**	**No**
If yes, year of diagnosis: _____		
Do you have, or have you had:		
Angina	Yes	No
Heart attack or myocardial infarction	Yes	No
Coronary bypass surgery	Yes	No
Palpitations (abnormal heart beat)	Yes	No
Heart valve problems	Yes	No
Pulmonary hypertension	Yes	No
Congestive Heart Failure	**Yes**	**No**
If yes, year of diagnosis: _____		
High Blood Pressure	**Yes**	**No**
If yes, year of diagnosis: _____		
Elevated Cholesterol	**Yes**	**No**
If yes, year of diagnosis: _____		
Elevated Triglycerides	**Yes**	**No**
If yes, year of diagnosis: _____		
Diabetes	**Yes**	**No**
If yes, year of diagnosis: _____		
Juvenile onset	Yes	No
Gestational (pregnancy-induced)	Yes	No
Adult onset	Yes	No
Diet controlled	Yes	No
Oral medications	Yes	No
Insulin	Yes	No
Asthma	**Yes**	**No**
If yes, year of diagnosis: _____		
Shortness of Breath	**Yes**	**No**
If yes, you can walk _____ blocks and climb _____ flights of stairs		
Have you been diagnosed by a physician with sleep apnea?	**Yes**	**No**
If yes, do you use a CPAP or BiPAP machine?	Yes	No
Have you had corrective surgery?	Yes	No
Has anyone told you that you stopped breathing while sleeping?	Yes	No
Sleep difficulties: Snoring	Yes	No
Awakenings at night	Yes	No
Daytime drowsiness	Yes	No
Observed apnea spells	Yes	No
Morning headaches	Yes	No

Reflux/Heartburn/Esophagitis/Hiatal Hernia	**Yes**	**No**
If yes, year of diagnosis: _____		
Prescription medications:	Yes	No
Over-the-counter medications:	Yes	No
Frequency of use: _____		
Endoscopy:	Yes	No

Venous Stasis	**Yes**	**No**
Leg or ankle swelling/edema	Yes	No
Leg ulceration	Yes	No
Leg skin color change or thickening	Yes	No

Pain or Arthritis of Ankles/Knees/Hips	**Yes**	**No**
Limits ability to walk or exercise	Yes	No
Prescription medications	Yes	No
Over-the-counter medications	Yes	No

Low Back Pain/Sciatica	**Yes**	**No**
Limits ability to walk or exercise	Yes	No
Prescription medications	Yes	No
Over-the-counter medications	Yes	No

Urinary Incontinence (leakage of urine)	**Yes**	**No**
With coughing/sneezing/straining	Yes	No
Number of times per week: _____		

Migraine Headaches	**Yes**	**No**
Frequency: _____		
Prescription medications	Yes	No
Over-the-counter medications	Yes	No

Deep Venous Thrombosis (blood clots in legs)	**Yes**	**No**
If yes, year of diagnosis: _____		
Pulmonary embolism	Yes	No
Blood thinning medication	Yes	No

Abdominal Wall Hernia	**Yes**	**No**
Incisional	Yes	No
Umbilical (belly button)	Yes	No
Number of hernia repairs and dates:		
_____		
Hernia currently present	Yes	No

Past Medical History:

Please list all medical conditions or illnesses not previously mentioned in this questionnaire:

Please list all non-surgical hospitalizations you have experienced as an adult:

Reason	Hospital	Date

Past Surgical History:

Please list all surgical procedures or operations you have had:

Procedure	Reason	Hospital	Date

Do you have allergies to any medications? ☐ **Yes** ☐ **No**

If yes, please list medications and reactions (e.g., rash, difficulty breathing, shock, etc.):

Have you ever received a blood transfusion? ☐ Yes ☐ No

Have you ever had hepatitis? ☐ Yes ☐ No

Have you ever been exposed to HIV/AIDS? ☐ Yes ☐ No

Have you ever abused intravenous (IV) drugs? ☐ Yes ☐ No

Medications: Please list all medications you currently use, including non-prescription medications, vitamins, dietary supplements, and herbal remedies.

Name of Medication	**Dosage & Frequency**	**Reason**

Family History:

Please indicate which **family member** has had any of the following illnesses:

☐ Obesity	☐ Lung disease or emphysema	☐ Kidney disease
☐ High blood pressure	☐ High cholesterol	☐ Diabetes
☐ Heart disease	☐ Breast cancer	☐ Blood disorder
☐ Stroke	☐ Other cancers	☐ Bleeding tendency

Is your mother still alive? ☐ Yes ☐ No

If not, what was the cause of death and age at death? _____

Is your father still alive? ☐ Yes ☐ No

If not, what was the cause of death and age at death? _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No If yes, how many? _____

Occupation: _____

Do you use tobacco? ☐ Yes ☐ No If yes:

Cigarettes: Number packs per day: _____ Years of tobacco use: _____

Cigars: Number per day: _____ Years of tobacco use: _____

Pipe: Number times per day: _____ Years of tobacco use: _____

Smokeless: Number times per day: _____ Years of tobacco use: _____

Do you use alcohol? ☐ No ☐ Yes Amount and frequency: _____

Do you use recreational drugs? ☐ No ☐ Yes Frequency: _____

Have you ever been treated for depression? ☐ Yes ☐ No

Are you currently in treatment? ☐ Yes ☐ No

If yes, please indicate the name of your physician or therapist/counselor:

_____

Have you ever been hospitalized for mental illness? ☐ Yes ☐ No

If yes, please indicate date(s) and reason(s):

_____

Review of Body Systems:

Please circle any of the following you currently experience or have experienced in the past:

General

Fever	Fatigue
General weakness	Tiredness
Memory loss	Recent weight loss
Easy bruising	Night sweats
Abnormal bleeding	

Other _____

Head/Neck

Trouble with vision	Trouble with ears	Sinus trouble
Persistent hoarseness	Severe headaches	Dizziness
Fainting spells	Loss of smell	Sore throat
Difficulty swallowing	Pain when swallowing	Lump in neck

Other _____

Chest/Heart/Lungs

Shortness of breath	Poor exercise tolerance	Chest pain or pressure attacks
Fluttering of heart	Frequent cough	Wheezing
Coughing up blood	Swollen ankles	Night sweats
Heart attack	Pain in arms or neck	Heart pounding
Palpitations	Heart murmur	Abnormal heart beats
Low blood pressure	Stroke	Cold feet
Pain in legs	Asthma	Loss of pulses
Emphysema	Pneumonia	Bronchitis
Difficulty sleeping flat	Waking at night short of breath	

Other _____

Stomach/Intestines/Abdomen

Poor appetite	Indigestion or heartburn	Difficulty swallowing
Nausea or vomiting	Vomiting blood	Abdominal pain or cramps
Abdominal swelling	Diarrhea	Constipation
Change in bowel habits	Pass blood from rectum	Black, tar-like bowel movements
Jaundice	Hepatitis	Cirrhosis
Heartburn	Abdominal pain	Pain with bowel movements
Change in stool size	Hemorrhoids	Irritable bowel
Colitis		

Other _____

Kidneys/Urinary

Kidney stones	Blood in urine	Pain/burning while urinating
Difficulty passing urine	Difficulty controlling urine	Getting up at night to urinate
Frequent urination	Leakage of urine	Kidney infection
Bladder infection	Pelvic examination/PAP smear within past year	

Other _____

Bones/Joints

Weakness in arm or leg	Painful joints	Gout
Loss of muscle strength	Swollen joints	Back pain
Lump or swelling in muscle	Arthritis	Muscular aches
Pain in knees	Pain in hips	Pain in feet
Pain in ankles	Sciatica	Low back pain
Numbness in feet or legs	Herniated disk	Abnormal lumps or masses

Other _____

Endocrine

Hyperthyroid	Low thyroid	Goiter
Previous radiation	Diabetes	Adrenal gland tumor
Swollen glands	Cold when others are not	Hot when others are not
Persistent thirst	Previous steroid (corticosteroids, cortisone) use or injections	

Other _____

Skin

Changing mole	Rash	Burns
Skin cancer		

Other _____

Muscular/Nervous System

Seizures	Convulsions	Fainting
Dizziness	Light headedness	Falling
Muscle weakness	Numbness	Tremors
Loss of consciousness	Strokes	

Other _____

Psychological

Depression	Nervousness	Suicidal thoughts
Suicide attempts	Schizophrenia	Anorexia
Bulimia	Binge eating	Mental health counseling
Hospitalization for emotional problems		

How would you describe your life? Unsatisfactory / Satisfactory Boring Other

Do you: Cry easily? Feel anxious or upset? Have difficulty with sleep?

Other _____

Females only

Breast lump	Discharge from nipple	Hot flashes
Possibly pregnant	Irregular periods	Mammogram within past year
Vaginal discharge	Vaginal bleeding or spotting (between periods)	

Other _____

Males only

Prostate trouble	Discharge from penis	Sores on penis
Lump in testicles	Difficulty having erections	

Other _____