WITTGROVE BARIATRIC *CENTER*

PATIENT 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.

<table>
<tr><td colspan="2">Name:</td><td colspan="2">Date:</td></tr>
<tr><td>Age:</td><td>Gender:

Male   Female</td><td colspan="2">Occupation: (If retired, what did you do?)</td></tr>
<tr><td>Actual Body Weight</td><td>Your Measurement</td><td>Nurse Consult Measurement</td><td>Pre-Operative Measurement</td></tr>
<tr><td>Height</td><td></td><td></td><td></td></tr>
<tr><td>Ideal Body Weight</td><td></td><td></td><td></td></tr>
<tr><td>Excess Body Weight</td><td></td><td></td><td></td></tr>
<tr><td>Target Weight</td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Body Frame

Small

Medium

Large</td><td></td><td>BMI:</td><td>BMI:</td></tr>
<tr><td></td><td>Waist:</td><td>Waist:</td></tr>
<tr><td></td><td>Hips:</td><td>Hips:</td></tr>
</table>

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	**Age**	**Weight**
Birth weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

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

____

____

____

____

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

DIETARY HISTORY

Approximate age when you first seriously dieted: ______________________

List the diets and diet programs you have tried:

Program			**Dates**	**Duration**	**MD Supervised?**	**Max Loss**
Jenny Craig:	Yes _	No _				
Nutri-Systems	Yes _	No _				
Weight Watchers	Yes _	No _				
OptiFast	Yes _	No _				
Medi Fast	Yes _	No _				
Fen/Phen/Redux	Yes _	No _				
Meridia	Yes _	No _				
Lindora	Yes _	No _				
T.O.P.S.	Yes _	No _				
O.A.	Yes _	No _				
Acupuncture	Yes _	No _				
Metabolife	Yes _	No _				
Atkins Diet	Yes _	No _				
Pritikin Diet	Yes _	No _				

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

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

For female patients only:

Pregnancy #1 Year_________ Weight at start__________ at delivery__________

Pregnancy #2 Year_________ Weight at start__________ at delivery__________

Pregnancy #3 Year_________ Weight at start__________ at delivery__________

Pregnancy #4 Year_________ Weight at start__________ at delivery__________

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from **1– like very much** to **4– don't care.**

_____Soda/Soft drinks
_____French fries
_____Chips/snacks
_____Steaks/chops
_____Candy
_____Potatoes
_____Chocolate
_____Pasta
_____Cookies
_____Pizza
_____Cakes/pies
_____Salad dressings
_____Fried foods

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: ____________________________

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

5. Asthma _ Yes _ No

If Yes: ♦Year Diagnosed: ____________________________

♦ER visits/last 2 yrs: ____________________________

♦Hospitalizations last 2 years: ____________________________

♦Steroids last 2 years: _ Yes _ No

6. Shortness of breath _ Yes _ No

If Yes, : ♦Can walk ________________blocks

♦Stairs: ________________ flights

7. Trouble Sleeping? _ Yes _No

♦Morning headaches _Yes _ No

♦Daytime drowsiness _ Yes _ No

♦ Restless sleep _ Yes _No

♦Snoring _Yes _No

♦Awakenings at night _Yes _ No

♦Observed apneas _Yes _ No

Office Use: _ sleep study ordered __________ initials

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

Office Use: *UGI/endoscopy*

12. Gallbladder disease? _ Yes _ No

If Yes: -How was it Diagnosed? _ Ultrasound _ Physical Exam

13. Leakage of urine with laughing/coughing/sneezing? _ Yes _ No

If Yes: ♦Wear pads frequently? _ Yes _ No

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

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: ____________________

____

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
- Using Medication? ____________________

19. Bra size (females only): __________
- Skin depressions from bra straps? _ Yes _ No
- Do you have shoulder pain? _ Yes _ No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

_ Measles _ Mumps _ Chickenpox _ Obesity
_ Rheumatic fever _ Heart murmur _ Asthma _ Tonsillectomy

Female Patients:

Number of pregnancies: __________ Age at first period: __________
Number of live births: __________ Date of last period: __________
Miscarriages/abortions: __________
Obstetric complications: ____________________

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

Do you presently use:

Birth control pills _ Yes _ No List type: ______________________________

Estrogens _ Yes _ No List type: ______________________________

Other Contraceptive method: ______________________________

Serious Illnesses:

Have you had:

_ Hepatitis _ Blood Transfusion _ AIDS/HIV Exposure

_ Colitis _ Kidney Disease _ Bleeding Abnormality

_ Thyroid Problems ______________________________

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

Major Illness Date Treatment

____

____

____

____

____

Major Surgery Date

____

____

____

____

____

____

Allergies:

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

____

____

____

Allergic to: **Surgical tape**: _ Yes _ No **Latex**: _ Yes _ No **Iodine**: _ Yes _ No

Other Allergies:

____

____

WITTGROVE BARIATRIC *CENTER*

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

Do you use alcohol: _ Yes _ No Frequency: ______________________________

FAMILY HISTORY

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

Please indicate if there is a family history of:

_ Obesity
_ Diabetes
_ High Blood Pressure
_ Heart Disease
_ High Blood Cholesterol
_ Lung disease, Asthma or Emphysema
_ Kidney Disease
_ Bleeding tendency or Blood Disorder
_ Breast Cancer
_ Colon Cancer

WITTGROVE BARIATRIC *CENTER*

Name:	Date:

Personal Physicians:

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

	Name	Address/Location	Telephone
Primary Care Physician			
Internist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Therapist			
Other			

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experience in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy Nose – runny Nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – 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

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

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5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – 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

♦Men: discharge from penis – loss of erection – painful erection
♦Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – xray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling