

**HEALTH QUESTIONNAIRE**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Office Use
HT: _____
WT: _____
BMI: _____
Waist: _____
Hip: _____
Waist/Hip
Ratio: _____
Goal Weight: _____

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender:  Male  Female SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Married  Divorced  Single  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Spouse's Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Voter registration Number: \_\_\_\_\_

Driver's License: \_\_\_\_\_ State: \_\_\_\_\_ Driver's License: \_\_\_\_\_ State: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Employed  On disability  Not employed

Employer Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

How long with employer? \_\_\_\_\_

Previous Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

How long with employer? \_\_\_\_\_

List the names of **three persons** who know your whereabouts and can be called in case of emergency other than those living with you in the same household.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

Please list the names of all your **grown children** with their address and phone number.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: home: (\_\_\_\_) \_\_\_\_\_ work: (\_\_\_\_) \_\_\_\_\_

**I acknowledge that I have received a copy of the organization's Notice of Privacy Practice that describes how my health information is used and shared.**

\_\_\_\_\_  
**Patient Signature**

Please **mark (✓)** those which apply to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Overweight since childhood | <input type="checkbox"/> Overweight in middle school          | <input type="checkbox"/> Overweight in high school   |
| <input type="checkbox"/> Overweight after pregnancy | <input type="checkbox"/> Other _____                          |  |
| <input type="checkbox"/> Eats frequent meals        | <input type="checkbox"/> Eats large meals                     | <input type="checkbox"/> Eats without feeling hungry |
| <input type="checkbox"/> Diet on my own             | <input type="checkbox"/> Participated in weight loss programs |  |
| <input type="checkbox"/> Lowest weight: _____       | <input type="checkbox"/> Highest weight: _____                |  |

List the names of supervised and medically supervised **diet programs** you have participated in the last 10 years:

Name of Program	Duration in Months	Weight Lost in Pounds

List the names of medications you **have taken** in the last 10 years to lose weight:

Name	Dose	Duration in Months	Weight Lost in Pounds

List the all medications that you are **taking** now (including over the counter medications):

Name	Dose	Name	Dose

List names of medications that you are **allergic** to: \_\_\_\_\_

- Are you taking any blood thinners or aspirin related products?    Yes                       No  
 Do you smoke:  Yes    No    Do you drink alcohol:  Yes    No    Do you exercise:  Yes    No  
 How do you rate your health?   Excellent        Good                      Fair

Please circle any of the following medical conditions you have been diagnosed with:

- |  |                                       |  |   |   |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Heart attack/failure      | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Varicose veins  | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Blood clots in legs       | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Sleep apnea/snoring   | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Gall bladder stones  | <input type="checkbox"/> High blood sugar |
| <input type="checkbox"/> Stomach ulcer   | <input type="checkbox"/> Depression   | <input type="checkbox"/> Back /knee pain/Arthritis | <input type="checkbox"/> Blood in stool/uring | <input type="checkbox"/> Pneumonia        |
| <input type="checkbox"/> Easy bruising   | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Heat/cold intolerance     | <input type="checkbox"/> High triglycerides   | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Other _____          |   |
| <input type="checkbox"/> Heartburn, how often ⇨ <input type="checkbox"/> once weekly <input type="checkbox"/> once daily <input type="checkbox"/> more than once daily |                                       |  |   |   |

Have you had an **operation for weight loss**? Yes   No    If yes please list the type of surgery performed, the year it was done, the surgeon, and where the operation was performed and amount of weight lost.

Name of surgery	Date	Name of Surgeon	Name of Hospital	Weight lost in Pounds

List all **other operations** you had:

Name of surgery	Date	Name of Surgeon	Name of Hospital

**Past Hospitalizations excluding surgeries:**

Diagnosis	Approx. Date	Diagnosis	Approx. Date

**Family History**

	Age	Health	Disease	Overweight?
Father				
Mother				
Siblings				
Other				

**For women:**

Pregnancies: Number \_\_\_\_\_ Dates: \_\_\_\_\_  
                    Natural Delivery       C-section  
 Date of last menstrual period \_\_\_\_\_  
 Hormone therapy:       Yes     No  
 Form of birth control: \_\_\_\_\_  
 Last check up: \_\_\_\_\_  
 Birth control history:  
     Bilateral tubal ligation                       Yes     No  
     Hysterectomy                                     Yes     No  
     Significant other vasectomy/other         Yes     No

**THE EPWORTH SLEEPINESS SCALE**

Do you snore while sleeping?                       Yes                       No  
 Does your bed partner say you snore?             Yes                       No  
 Does your bed partner say that you stop breathing while sleeping?     Yes                       No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

0        =        would *never* doze  
 1        =        *slight* chance of dozing  
 2        =        *moderate* change in dozing  
 3        =        *high* chance of dozing

Situation	Chance of dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____
<b>TOTAL:</b>	_____