

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	_____
TOTAL:	_____