

Patient Demographic and Medical History Questionnaire

Date Form Completed: _____

How did you hear about us? Family/Friend Doctor Internet TV Newspaper Other _____

Have you ever started the process to have weight loss surgery in the past? YES NO

If yes, what year? _____ If yes, what program/city? _____

(if here at Georgetown, we will pull your chart and update your information)

If yes, for what reason(s) did you stop process to surgery? _____

Have you had prior "stomach stapling" or other gastric restriction/bypass procedure? YES NO

(if yes, please provide further information when entering in your surgical history in the applicable section)

Are you able to read, write and communicate in the English Language? YES NO

If not, what is your primary language? _____

Please check any other barriers to communication applicable:

Hearing impaired (deafness or other) Vision impaired (blindness or other) Cannot read or write

We will work with you on accommodations to ensure you receive all of the information you need!

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender: Female Male

Marital Status: Married Single Divorced Separated Partnered Widowed

How many children do you have (please also list ages)? _____

Ethnicity: African American Asian Caucasian Hispanic Native American or Alaska Native

Native Hawaiian or Other Pacific Islander Choose not to specify Other : _____

Religious affiliation: _____

Patient's level of Education: _____

Address Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone (home): _____

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

Patient Employment/Mobility Information:

Employment status: Full Time Part Time Retired Disabled Homemaker Student
Unemployed Leave of Absence

Patient's present or former occupation: _____

Patient's Current Employer: _____ Years Employed: _____

Patient's Employer's address: _____

Disabled? Yes No If Yes, specify the year and cause: Year: _____ Cause: _____

Can you walk unassisted? Yes No How far before needing rest? _____ (approximate # of feet)

If you need assistance walking, what device(s) do you use (circle all that apply)?

Cane Walker Crutches Other: _____

Are you wheelchair bound and unable to stand at all? Yes No How long in wheelchair? _____ (months/years)

Spouse Employment Information

Spouse's Name: _____ Spouse's date of birth: _____
Spouse's employment status: Full Time Part Time Retired Disabled Housewife
Student Unemployed Leave of Absence
Spouse's Occupation: _____ Spouse's SSN: _____
Spouse's employer: _____ Years employed: _____
Spouse's employer's address: _____

Preferred Procedure (if known): Roux-en-Y Gastric Bypass Laparoscopic Adjustable Gastric Banding

Gastric Sleeve Revision (Revision/conversion procedure for prior weight loss surgery)

What is your height? _____ft _____in How much do you weigh? _____lbs. BMI _____

Insurance Information – *This section must be filled out in addition to enclosing a copy of your insurance card!*

Payment Type: Insurance Self Pay

Primary Insurance

Insurance Company: _____
Policy Number: _____ Group #: _____
Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary Insurance (if applicable)

Insurance Company: _____
Policy Number: _____ Group #: _____
Subscriber Name: _____ Subscriber Date of Birth: _____

Emergency Contact (if different from spouse)

First Name: _____ Last Name: _____
Relation to you: _____ Phone: _____

Do you have a designated Medical Surrogate, Health Care Power of Attorney or anyone who can legally make medical decisions for you? YES NO

If yes, who is that person(s)? _____ Relationship to you? _____

Authorization to discuss/review medical care plan

"I hereby authorize the staff of the Bariatric Center at Georgetown Community Hospital to discuss my condition/treatment/plan of care, diagnostic test results and any scheduled appointments with the following named person(s), **and/or** further consent to the staff leaving messages for me on voicemail/answering machine":

Name: _____ Relation to you: _____

Name: _____ Relation to you: _____

Patient Signature: _____ Date: _____

Primary/Referring Physician

Do you have a physician who can document your weight loss attempts for at least 6 months if required? Yes No

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Have you discussed Weight Loss Surgery with your physician? Yes No If Yes, is your physician supportive? Yes No

Blood Consent

*You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (*if Jehovah's witness please check: O)

Patient Signature: _____ Date: _____

Weight Loss History

How long have you been overweight? _____ Years

How long have you been 30 pounds or more overweight? _____ Years

If applicable, how long have you been 100 pounds or more overweight? _____ Years

Can your weight and health history be documented by a medical provider if required? Yes No

When did you start dieting? _____ Age Check if no prior diet attempts of any kind

What is the most weight you have ever lost on a single diet? _____ lbs.

How did you lose the weight? _____ How long did you sustain the weight loss? _____ (months/years)

Check all that apply:**Unsupervised Diet Attempts:**

- | | | |
|---|--|--|
| <input type="radio"/> Body for Life/Bill Phillips | <input type="radio"/> Stillman Diet | <input type="radio"/> Calorie Counting |
| <input type="radio"/> Pritkin | <input type="radio"/> Herbal Life | <input type="radio"/> Cabbage Soup |
| <input type="radio"/> Gloria Marshall | <input type="radio"/> Sugar Busters | <input type="radio"/> South Beach |
| <input type="radio"/> Richard Simmons | <input type="radio"/> Low Carbohydrate | <input type="radio"/> Atkin's Diet |
| <input type="radio"/> Health Spa | <input type="radio"/> Slim Fast | <input type="radio"/> Other_____ |
| <input type="radio"/> Scarsdale | <input type="radio"/> Low Fat | |
| <input type="radio"/> High protein | <input type="radio"/> Mayo Clinic | |

Supervised Diet Attempts:

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="radio"/> Nutri-Systems | <input type="radio"/> Overeaters Anonymous | <input type="radio"/> Weight Watchers |
| <input type="radio"/> T.O.P.S | <input type="radio"/> LA Weight Loss | <input type="radio"/> HMR |
| <input type="radio"/> Diet Center | <input type="radio"/> Optifast | <input type="radio"/> DASH |
| <input type="radio"/> Jenny Craig | <input type="radio"/> National Weight Loss | <input type="radio"/> Other_____ |

Over-the-Counter or Prescribed Medications for Weight Loss:

- | | | |
|---|--|---|
| <input type="radio"/> Amphetamines
(phenolpropanolamine) | <input type="radio"/> Ionamin/Adipex | <input type="radio"/> Meridia (sibutramine) |
| <input type="radio"/> Accutrim | <input type="radio"/> Fastin/Pro-Fast | <input type="radio"/> Xenical/Alli (orlistat) |
| <input type="radio"/> Dexatrim | <input type="radio"/> Redux (dexfenfluramine) | <input type="radio"/> Antidepressant |
| <input type="radio"/> Didrex (benzphetamine) | <input type="radio"/> Fen-Phen: # Months_____ | <input type="radio"/> Diuretics ("fluid pills") |
| <input type="radio"/> Byetta (exenatide) | <input type="radio"/> Pondimin (fenfluramine) | <input type="radio"/> Laxatives |
| <input type="radio"/> Phentermine | <input type="radio"/> Redux (dexfenfluramine) | <input type="radio"/> Other_____ |
| | <input type="radio"/> Tenuate (diethylpropion) | |

Behavioral Treatments for Weight Loss:

- Hospitalization
- Hypnosis
- Physical Therapy
- Psychological Therapy
- Residential Programs
- Other_____

Exercise:

- Walking or Running
- Stationary cycle or treadmill
- Swimming
- Weight Training
- Team Sports
- Other_____

Have you used any of the following behaviors to control your weight? (Check all that apply)

- Bingeing and then Vomiting
- Bingeing followed by food restriction
- Vomiting
- Excessive Calorie Restriction/Fasting
- Excessive Exercise

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? Yes No

Current Eating Habits (which may help inform your choice of Bariatric surgery)

Do you snack frequently between meals? Yes No

Do you "graze" throughout the day/evening? Yes No

Do you eat large meals? (gorge) Yes No

Do you eat a lot of sweets/junk food? Yes No

Do you eat at fast food restaurants routinely? Yes No

Do you drink a lot of soda pop? Yes No Diet Regular

Do you drink coffee or other caffeine-containing drinks? Yes No

If yes, how many cups per day? _____

Do you drink carbonated beverages? Yes No

If yes, how many cans/bottles per day? _____

Why do you feel you overeat? (Check all that apply) Physical Hunger Loneliness Anxiousness Boredom
Makes me happy Helps me handle stress

What reasons do you feel contribute to you being overweight? (Check all that apply) Inactivity
Over Consumption
Poor food choices/lack of nutritional knowledge
Emotional Stressors

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

Why are you seeking weight loss surgery? _____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

If you use eating as an emotional outlet, what will you substitute when your eating is restricted? _____

Medical History/Review of Symptoms: (Check all that apply)

General / Head and Neck

Cancer: (list year of diagnosis, area of body affected and treatment received):

-
- | | |
|---|---|
| <input type="checkbox"/> Glaucoma / Eye disease | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Hearing Loss / aides |

Other symptoms (General):

- | | | |
|--|---|--|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Chills / Night Sweats | <input type="checkbox"/> Appetite Change / Loss | <input type="checkbox"/> Fatigue / Tired / No Energy |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Other_____ |

Other symptoms (Head and Neck):

- | | | |
|---|---|--|
| <input type="checkbox"/> Wear contacts / glasses | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Blurred / Double Vision | <input type="checkbox"/> Repeated Ear Infections | <input type="checkbox"/> Altered taste |
| <input type="checkbox"/> Hearing Problems / Hearing aid | <input type="checkbox"/> Sinus Drainage | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Tinnitus (ringing in ears) | <input type="checkbox"/> Seasonal Allergies / Hay fever | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Vertigo (room spinning) | <input type="checkbox"/> Dentures or partials | <input type="checkbox"/> Other_____ |
| | <input type="checkbox"/> Gum problems / bleeding | |

Cardiovascular

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure: <input type="radio"/> Borderline/No medication <input type="radio"/> Single medication <input type="radio"/> Multiple medications <input type="radio"/> Poorly controlled | | |
| <input type="checkbox"/> Poor circulation in legs/Peripheral Vascular Disease: <input type="radio"/> Medication <input type="radio"/> Surgery/revascularization | | |
| <input type="checkbox"/> Deep blood clot in leg (DVT): <input type="radio"/> resolved with anticoagulation <input type="radio"/> recurrent | | |
| <input type="checkbox"/> Blood clot in lungs (pulmonary embolism): <input type="radio"/> resolved with anticoagulation <input type="radio"/> recurrent <input type="radio"/> vena cava (Greenfield) filter placed | | |
| <input type="checkbox"/> Heart disease/Prior Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Rheumatic Fever / Valve Damage |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Atrial Fibrillation / Arrhythmia | <input type="checkbox"/> Prior Stroke or TIA |

Other symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Ankle Swelling / Edema: <input type="radio"/> Diuretic ("fluid pill") | | |
| <input type="checkbox"/> Chest Pain with Activity | <input type="checkbox"/> Irregular Heartbeat / Skipped Beats | <input type="checkbox"/> Cramping in legs when walking |
| <input type="checkbox"/> Shortness of Breath with Exercise | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Difficulty breathing when lying flat | <input type="checkbox"/> Very slow Heart Rate | |
| | <input type="checkbox"/> Ankle/Leg Ulcers | |

Endocrine

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes: <input type="radio"/> oral medication only <input type="radio"/> Insulin only <input type="radio"/> oral medication and insulin <input type="radio"/> complications (neuropathy/organ damage) | | |
| <input type="checkbox"/> Elevated Cholesterol / Triglycerides: <input type="radio"/> diet modification <input type="radio"/> single medication <input type="radio"/> multiple medications | | |
| <input type="checkbox"/> Gout: <input type="radio"/> no active symptoms <input type="radio"/> medication <input type="radio"/> joint destruction/disability | | |
| <input type="checkbox"/> Under / Overactive Thyroid | <input type="checkbox"/> "Prediabetes" / "Insulin Resistance" with elevated Blood Sugar | <input type="checkbox"/> Gestational Diabetes (during pregnancy) |
| <input type="checkbox"/> Parathyroid/ High calcium | | |
| <input type="checkbox"/> Endocrine Gland Tumor | | |

Other symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Excessive Sweating |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Abnormal Facial Hair Growth | |

Respiratory

- Asthma: inhaler(s) oral meds not controlled multiple hospitalizations required
- Obstructive Sleep Apnea: symptoms but negative or no formal sleep study diagnosed but no appliance CPAP or BiPAP
- COPD/Emphysema: Recurrent Bronchitis / Pneumonia Pulmonary hypertension/
 supplemental oxygen Prior Tb right heart failure

Other symptoms:

- Chronic Cough Snoring Other_____
- Shortness of breath at rest Abnormal breathing pattern
- Coughing up blood Wheezing

Gastrointestinal Date of last colonoscopy, if done: _____

- GERD/Heartburn: no medication intermittent medication daily medication prior surgery
- Gallbladder Problems/Gallstones: intermittent symptoms prior gallbladder removal ongoing/unresolved complications
- Abnormal Liver findings / Elevated Liver Enzymes: enlarged liver elevated enzymes NASH Liver failure
- Barrett's Esophagus Pancreatic Disease Hemorrhoids / Fissure
- Achalasia / motility disorder Cirrhosis / Hepatitis Incisional / Abdominal Hernia
- Hiatal Hernia Colitis / Crohn's Disease Other hernia: _____
- Stomach Ulcer / +H. pylori Irritable Bowel (IBS)

Other symptoms:

- Difficulty Swallowing Excessive gas or bloating Rectal Bleeding/Blood in stool
- Belching / regurgitation Diarrhea Polyps
- Nausea / Vomiting Constipation Incontinence of stool
- Abdominal Pain Change in Bowel Habit Other_____
- Jaundice Black, tarry stools

Bladder/Kidney

- Leaking urine with cough/laugh/sneezing: intermittent daily; requires sanitary pad disabling or prior surgery
- Kidney Stones: *Treatment including (if applicable):* medication prior surgical procedure or lithotripsy (ESWL)
- Kidney Failure / Renal Insufficiency

Other symptoms:

- Blood in Urine Trouble starting urine Terminal dribbling
- Burning / Pain on urination Urinary Urgency/Frequency Other_____
- Overall Loss of bladder control
(global leakage) Decreased force of stream
- Incomplete emptying

Musculoskeletal / Autoimmune

- Back Pain: intermittent non-narcotic treatment narcotic medication prior or recommended surgery failed surgery
- Other Joint pain: non-narcotic treatment pain with walking prior surgery past or recommended surgery
- Fibromyalgia: exercise non-narcotic treatment narcotic medication surgery disabling; treatment ineffective
- Arthritis Lupus Plantar Fasciitis
- Sciatica Scleroderma
- Rheumatoid Arthritis Carpal Tunnel Syndrome

Other symptoms:

- Neck Pain Hip Pain Ball of foot/Toe Pain
- Shoulder Pain Knee Pain Muscle Pain/Spasm
- Wrist Pain Ankle Pain Broken Bones
- Hand/Finger(s) Pain Foot/Heel Pain Other_____

Neurologic

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pseudotumor Cerebri (severe headaches with nausea, and possible loss of vision from high pressure in the brain) | <input type="checkbox"/> Restless Legs Syndrome |
| <input type="checkbox"/> Migraine | | |
| <input type="checkbox"/> Seizure or Convulsions | | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neuropathy/Nerve Damage | |

Other symptoms:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Frequent or Recurrent Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Balance Disturbance | <input type="checkbox"/> Head Injury/Knocked Unconscious | |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness/Tingling | |
| <input type="checkbox"/> Memory loss | | |

Psychiatric

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Bipolar Disorder ("manic-depression") | <input type="checkbox"/> Alcoholism / Substance Abuse |
| <input type="checkbox"/> Attention Deficit Disorder | | <input type="checkbox"/> Mental/Emotional Abuse |
| <input type="checkbox"/> Other psychiatric illness or condition (please describe): _____ | | |

Other symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Attempted suicide? | <input type="checkbox"/> Been sexually abused? |
| <input type="checkbox"/> Been physically abused? | <input type="checkbox"/> Been in a chemical dependency program? |
| <input type="checkbox"/> Been hospitalized for psychiatric problems? If so, when? (please also describe more fully in the space below) _____ | |
| <input type="checkbox"/> Had psychiatric care or counseling? If so, for what condition(s)? _____ | |
| If so, are you still seeing a counselor/psychiatric professional? Yes <input type="radio"/> No <input type="radio"/> | |

Are you currently taking medications for "nerves" or other mental health problems? Yes No

Please provide further details regarding any emotional, physical, mental, substance or other types of issues you have dealt with. This information is very important and will be kept confidential. Honesty is needed in order to provide you with the best possible support and treatment plan.

Blood/Lymphatic

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia (iron deficient) | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Prior blood Transfusion |
| <input type="checkbox"/> Anemia (vitamin B12 deficient) | <input type="checkbox"/> Superficial blood clot in leg / Phlebitis | <input type="checkbox"/> Blood thinning medicine use |
| <input type="checkbox"/> HIV / AIDS | | |
| <input type="checkbox"/> Low Platelets (thrombocytopenia) | <input type="checkbox"/> Bleeding/Clotting Disorder | |

Other symptoms:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Other_____ |
|--|--|-------------------------------------|

Testicular/Prostate (for men only) Date of last prostate exam: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> BPH (benign prostate hypertrophy) | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Testicular masses/asymmetry |
|--|---|--|

Gynecologic (for women only) Date of last PAP smear: _____

- Polycystic Ovarian Syndrome: no treatment birth control pills diabetic medication combination therapy
- How many pregnancies have you had? _____ Live births? _____ Miscarriages or abortions? _____
- Are you currently pregnant? Yes No History of problems conceiving? Yes No
- Do you plan to have more children? Yes No History of pregnancy or delivery complications? Yes No

Are you post menopausal? Yes No If so, age at Menopause onset: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Menstrual Irregularity /
Abnormal Periods | <input type="checkbox"/> No Menses | <input type="checkbox"/> Prior Uterine/Ovarian Cancer |
| <input type="checkbox"/> Excessively Heavy Periods /
Passage of clots | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Postmenopausal vaginal
bleeding | |

Date of last menstrual period if premenopausal? _____

Age Started Menses _____

Breast Date of last Mammogram: _____

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Breast Skin changes | <input type="checkbox"/> Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lumps / Fibrocystic Disease | <input type="checkbox"/> Nipple Discharge | |

Skin

- | | | |
|---|----------------------------------|------------------------------------|
| <input type="checkbox"/> Keloids (raised scars) | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Chronic abscesses or boils | <input type="checkbox"/> Eczema | |

Other symptoms:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Recurrent/chronic rashes under
skin Folds/Breasts | <input type="checkbox"/> Frequent Skin Infections | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Poor Wound Healing | <input type="checkbox"/> Skin ulcers | |
| | <input type="checkbox"/> Hair or Nail Changes / Fungus | |

Surgical Procedure(s):

	Year		Year
Gallbladder: open laparoscopic	_____	Peripheral Vascular Procedure	_____
Anti-reflux procedure/Nissen fundoplication	_____	Heart surgery: CABG/Other: _____	_____
Appendectomy: open laparoscopic	_____	Breast Biopsy	_____
Hysterectomy: abdominal vaginal	_____	Breast: lumpectomy mastectomy	_____
<input type="radio"/> Laparoscopic approach		Breast Cancer Radiation	_____
<input type="radio"/> Ovaries also removed		Wisdom Teeth	_____
Other Ovary Surgery Describe: _____	_____	Tonsillectomy	_____
Vasectomy	_____	Hernia: Type: _____	_____
Cesarean Section (if multiple, list all dates)	_____	Tubal Ligation ("tubes tied")	_____
Neck: Describe: _____	_____	Bowel resection	_____
Back: Describe: _____	_____	Vagotomy	_____
Hip: replacement fixation	_____	Other: _____	_____
Knee: replacement arthroscopy	_____	Other: _____	_____

Anesthesia: No Problems

Please tell us about any problems that you have had with anesthesia:

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Woke up during procedure | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heart Stopped | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Difficulty Waking Up | <input type="checkbox"/> Stopped Breathing | |

Previous Weight Loss Surgery (WLS) procedure: _____

(We will need a copy of the Operative Report from your previous weight loss surgery.)

Date of Surgery: _____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ Estimated Actual Lowest Weight Achieved: _____ Estimated Actual

List Prescribed Medications:**Taken for what condition:****Dosage/How Often:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.**Product:****Taken for what purpose:****Dosage/How Often:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AllergiesPlease **circle if allergic** and list your **Reaction****Substance/Medication** **No history of allergies to these products**

Latex	Reaction: _____
Tape (adhesives)	Reaction: _____
Iodine	Reaction: _____
IV Contrast Dye	Reaction: _____

Medications: List any medications that you are allergic to and your reaction **No Medication Allergies**

Foods: List Foods and the reaction **No Food Allergies**

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes (age of onset)							
High Blood Pressure							
Heart/ Cardiovascular Disease							
Heart Attack (age)							
Stroke (age)							
Cancer: Type and age of onset							
Arthritis/Joint Problems							
Elevated Lipids/ Cholesterol							
Schizophrenia							
Gallstones / Gallbladder problems							
Sleep Apnea							
Asthma							
COPD/ Emphysema							
Other (please list/describe)							
Death: List age and cause							
If Living, What age are they?							

Social History

Do you smoke now? Yes No

If yes, how many packs per day? Less than 1 pack/day 1 to 2 2 to 3 More than 3

Have you smoked in the past? Yes No

If yes, how many packs per day did you smoke? Less than 1 pack/day 1 to 2 2 to 3 More than 3

Do you use snuff or chew? Yes No

If yes, how frequently do you use snuff/chew? Less than once per day Once per day Several per day
Less than once per week Once per week Several per week

For how many years have you/did you use tobacco? _____ Years If you have quit, how long ago? _____

Do you consume alcohol now? Yes No

If yes, how many times per week? _____ How many drinks each time? _____

If yes, is anyone concerned about the amount you drink? Yes No

For how many years do/did you drink alcohol? _____ Years If you have quit, how long ago? _____ Years

Do you use street drugs now? Yes No

If yes, what drugs? _____

If yes, how frequently do you use these drugs? Less than once per day Once per day Several per day
 Less than once per week Once per week Several per week
 Once per month Several per month

For how many years do/did you use street drugs? _____ Years If you have quit, how long ago? _____ Years

How many hours a day do you watch TV? Never Rarely 3-5 hours 5+ hours

What hobbies do you have that are important to you? _____

Do you routinely engage in planned physical activity or exercise now? Yes No

If yes, how frequently: daily several times per week weekly Less than weekly

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life:

Married Life? 1 2 3 4 5

Present job/activities? 1 2 3 4 5

Overall satisfaction with yourself? 1 2 3 4 5

Describe your present life stressors: Finances Family Illness Work Friends
 (Check all that apply)

Describe the present support system you rely upon: Spouse Family Friends Church Co-Workers Others
 (Check all that apply)

Could someone help care for you if you were seriously ill? Yes No Who? _____

Are there people for whom you are the primary care giver? Yes No Who? _____

What is your greatest fear regarding the surgery? _____

What is your greatest hope regarding the surgery? _____

Are there other questions you would like us to address? _____

Thomas Sonnanstine, MD / Katherine Hanley, PAC

Date

Thank you for taking the time to fill out our Patient Demographic and Medical History Questionnaire. Please also complete the following Sleep Questionnaire, and Nutrition History.

Don't forget to include a copy of the front and back of your insurance card(s) and your Insurance Review Form when mailing this information back to us.

Sleep History Questionnaire

Ronald Shashy, MD

Symptoms During Sleep -

Check all that apply:

- Loud Snoring
- Gasping
- Daytime Sleepiness
- Difficulty Falling Asleep
- Difficulty Staying Asleep
- Awaken Too Early
- "I worry that I won't be able to fall asleep"
- Fatigue
- Morning Headaches
- Irritability/Depression
- Inability to Concentrate
- Sinus symptoms interfere with sleep
- Heartburn, Indigestion, Sour Taste
- Inability to move while going to sleep or waking up
- Vivid or life-like visions (people in room, etc.) while going to sleep or waking up
- Sudden weakness or feel your body go limp when angry or excited
- Irresistible urge to move arms or legs
- Creeping or crawling sensation in legs before falling asleep
- Legs or arms jerking during sleep
- Frequent urination disrupting sleep
- Sleep Walking or Sleep Talking

Date of prior sleep study if done: _____

Diagnosis: _____

Machine used, if applicable (please circle):

Bi-Pap C- Pap Other: _____

Current Sleep Habits

1. At what time do you usually get to bed?

2. How long does it take to fall asleep after lights out?

3. How often do you awaken at night?

4. Total time spent awake in bed?

5. I usually wake up at?

6. Total length of naps daily?

7. Do you work a rotating shift?

8. Do you have an unusual work schedule?

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these things, 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
- 2 = moderate chance of dosing
- 3 = high chance of dosing

Sitting and Reading _____

Watching TV _____

Sitting, inactive, in a public place
(movie theater or a meeting) _____

As a passenger in a care for an hour without a break _____

Lying down to rest in the afternoon _____

Sitting & talking with someone _____

Sitting quietly after lunch with alcohol _____

In a car, whole stopped for a few minutes in traffic _____

Total Points: _____

Nutrition History – Amy Crist, RD, LD

Name: _____ DOB: _____

Current height: _____ Current weight: _____ BMI: _____

- How many meals and snacks do you eat each day? _____ Meals _____ Snacks
- How many times a week do you eat the following meals away from home:
Breakfast _____ Lunch _____ Dinner _____
- What types of restaurants do you frequently visit and how many times weekly do you eat at each?
(Check all that apply) Fast-food _____ Diner/cafeteria _____
Sit- down Restaurant _____ Other _____
- What type of beverages do you usually drink? How many ounces of each do you drink a day?
Water _____ Milk: _____ Alcohol: _____
Juice _____ Whole milk _____ Beer _____
Soda _____ 2% milk _____ Wine _____
Diet soda _____ 1% milk _____ Hard liquor _____
Sports drinks _____
Iced tea _____ Iced tea with sugar _____
- Do you eat large meals (gorge)? _____ Do you eat a lot of sweet snacks _____
- What are your favorite food(s) you crave _____
- Typical snacks include: _____
- Do you wake up at night to eat? YES NO if yes, what do you snack on? _____
- Are you a "grazer" - nibbling on small amounts of food all during waking hours? YES NO if yes, what do you snack on? _____
- Are you a "night eater"- snacking or nibbling after your evening meal? YES NO
If yes, what do you snack on? _____
- Do you have any restrictions on your current diet? If so, what is restricted and why? _____

- Have you tried protein supplements? If so, please list. _____

- Are you currently doing any exercise? If yes, please describe. _____

