Patient Questionnaire

Date: _____ Primary Care Physician: _____

Name: _____
(First Name) (MI) (Last Name—Include Sr., Jr., III, etc.)

Address: _____

City: _____ State: _____ Zip: _____ Sex: ☐ Male ☐ Female

Phone: _____ Social Security #: _____ - _____ - _____

Email Address: _____ Pharmacy: _____

DOB: _____ Marital Status: _____ # of Children: _____

Age: _____ Height: _____ Weight: _____ Race: _____

How did you hear about us?

☐SMMC Employee ☐Health Fair ☐Yellow Pages ☐Friend/Family
☐Current Patient ☐Facebook ☐Newspaper ☐Other _____
_____ ☐Internet ☐Physician _____

A: Medical History

Do you have or have you had any of the following?

1. Diabetes ☐ **Yes** ☐ **No**

2. High Blood Pressure ☐ **Yes** ☐ **No**

3. Heart Disease ☐ **Yes** ☐ **No**
Check if you have any of the following:
☐Chest Pain ☐Angina ☐Coronary Artery Disease ☐Congestive Heart Failure ☐Heart Attack
If yes: Duration of problem: _____
Form of treatment (list medication and doses): _____

4. Stroke ☐ **Yes** ☐ **No**
If yes: Duration of problem: _____
Form of treatment (list medication and doses): _____

5. High Cholesterol ☐ **Yes** ☐ **No**

6. Arthritis ☐ **Yes** ☐ **No**

7. Muscle and Joint Pain ☐ **Yes** ☐ **No**
Check if you have any of the following:
☐Hip Pain ☐Knee Pain ☐Food and Ankle Pain ☐Back Pain
☐Multiple Sclerosis ☐Leg and Foot Swelling

8. Sleep Problems ☐ **Yes** ☐ **No**
Check if you have any of the following:
☐Sleep Apnea ☐Snoring ☐Early Fatigue

CPAP Machine: ☐ **Yes** ☐ **No**
If yes: Duration of problem: _____
Form of treatment (list medication and doses): _____

9. Breathing Problems ☐ **Yes** ☐ **No**

Check if you have any of the following:

☐Asthma ☐Shortness of Breath ☐Difficulty in Breathing ☐Snoring ☐Other _____

10. Gastro-esophageal reflux ☐ **Yes** ☐ **No**

Check if you have any of the following:

☐ Heartburn ☐ Difficulty Swallowing ☐Other _____

11. Thyroid Problems ☐ **Yes** ☐ **No**

12. Depression ☐ **Yes** ☐ **No**

13. Cancer ☐ **Yes** ☐ **No**

If yes: Duration of problem: _____

Form of treatment (list medication and doses): _____

_____

14. History of Deep Vein Thrombosis (DVT)/PE ☐ **Yes** ☐ **No**

15. Gallbladder Disease ☐ **Yes** ☐ **No**

If yes: Duration of problem: _____

Form of treatment (list medication and doses): _____

_____

Have you had your Gallbladder tested for stones? ☐ **Yes** ☐ **No**

If yes: How and when? _____

16. Do you experience Bowel incontinence? ☐ **Yes** ☐ **No**

17. Other medical problems

B: Surgery History

Have you had any previous surgery? ☐ **Yes** ☐ **No**

If yes please list them starting with the most recent:

Year	Hospital	Operation	Complications

C: Medication

Do you take any medications? ☐ **Yes** ☐ **No**

Medicine	Does	Duration Taking Medicine

D: Allergy History

Do you have any medication allergies? ☐ **Yes** ☐ **No**

Drugs	Reaction

E: Social History

Do you smoke? ☐ **Yes** ☐ **No**
If yes: _____ packs/day for _____ years

Do you drink alcohol? ☐ **Yes** ☐ **No**
If yes: _____ drinks per week

Do you use recreational drugs? ☐ **Yes** ☐ **No**
If yes: types: _____

F: Family Medical History

Check if you have a family history of:

Blood Clots	☐ **Yes**	☐ **No**
Obesity	☐ **Yes**	☐ **No**
Heart Disease	☐ **Yes**	☐ **No**
Stroke	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**
Other	☐ **Yes**	☐ **No**

If yes, please fill in the details for the family member with the medical problem and specify. Also, please specify cause of death if family member is deceased.

Mother	Father

G: Weight Loss Attempts

Insurance companies request the period of time you have been engaged in attempts to lose weight and professionals you may have consulted. So, Please answer the following as completely as possible.

Have you participated in a commercial weight loss program? ☐ **Yes** ☐ **No**
If yes, please provide details:

Program	Dates Attended	Total Weight Loss	Duration of Loss
Weight Watchers			
Advocare			
L.A. Weight Loss Program			
Slimfast/Shakes			
Jenny Craig			
Atkins/South Beach			
Nutrisystem			
Mediterranean Diet			
Others (i.e. Book and videos)			

Have you been involved in medically or professionally supervised programs? ☐ **Yes** ☐ **No**
If yes, please list:

Doctor/Nutritionalist	Duration	Outcome

Have you been prescribed any weight loss medications (i.e. Phen-fen, Adipex, Xenical, Meridia, Phentermine, Alli, Stackers, Hydroxycut, Lipozene, Garcinia Cambogia, HCGetc.)? ☐ **Yes** ☐ **No**

If yes, please list: _____

Medication	Duration of Use	Weight loss	Duration of Loss	Reason Stop Medication

H: Weight History

Since when have you been overweight? _____

What was your biggest weight loss (lbs) and how long did it take you? _____

_____

How long did it take you to regain the weight? _____