Bariatric & Metabolic Institute

New Patient
History Questionnaire

For office use only:
Height: Weight:
NC: WC: BMI:

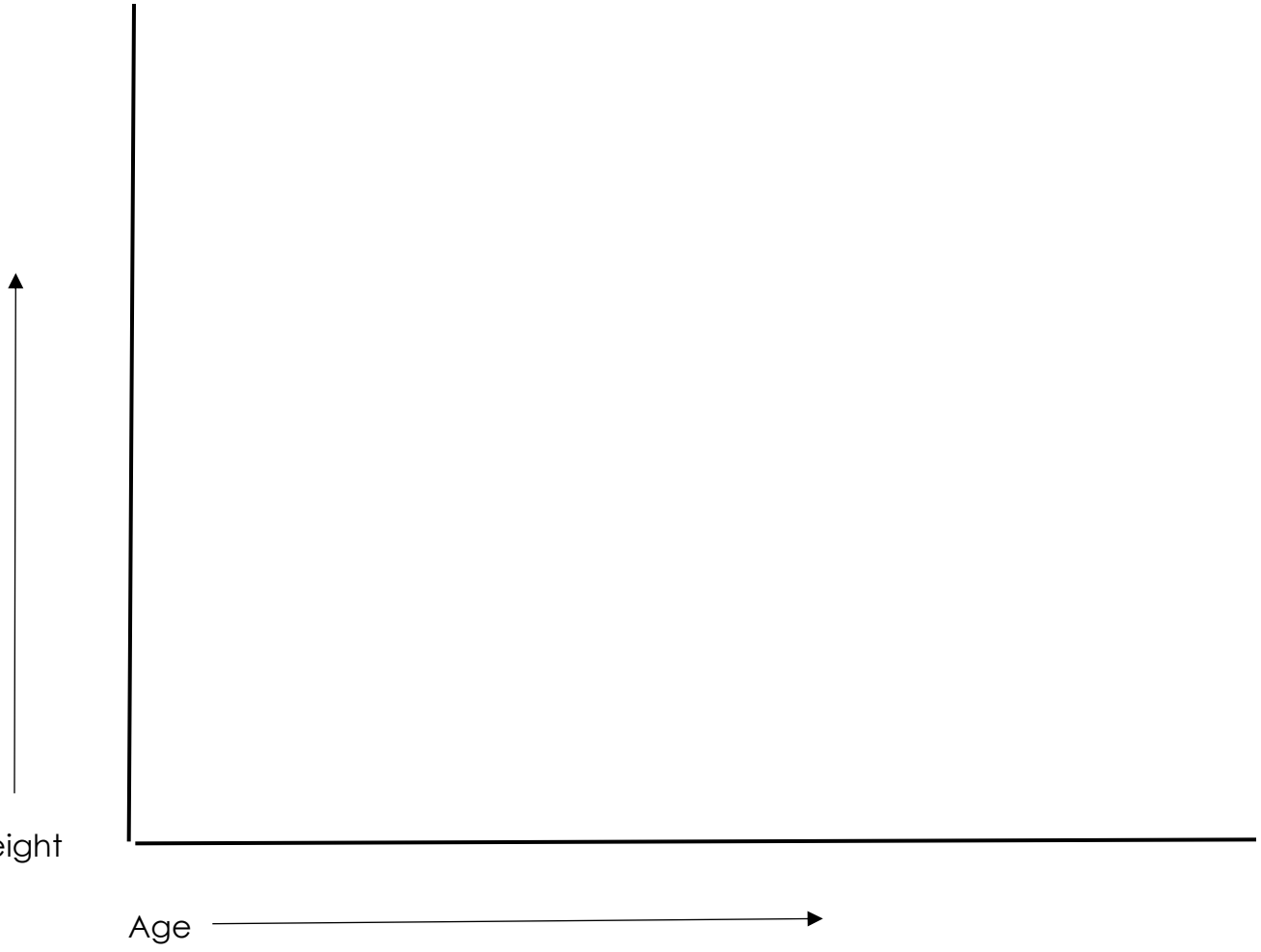
Name: Age:

How did you hear about us? Who referred you?

Who is your primary care physician?

What are your weight loss goals?

Please describe your weight history by drawing a graph of life events that affected your health and/or weight status (see last page for example):



Health Conditions (Please check all that apply)

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes/Pre-Diabetes
- ☐ Sleep Apnea
- ☐ Do you use a CPAP?
- ☐ Heartburn/Reflux
- ☐ Hip/Knee/Foot Pain
- ☐ Back Pain
- ☐ Fatty Liver

If you have reflux, how often do you have symptoms?
Do medications control your symptoms effectively? Y N

Other medical diagnoses:

List previous surgeries and dates:

List medications and dosages:

List any nutritional supplements (vitamins, minerals, herbals, protein supplements, etc.):

List any drug allergies or intolerances:

List any food allergies or intolerances:

Please complete the following if you have not already been diagnosed with sleep apnea:

	check	**yes**	**no**
Do you SNORE loudly? (Louder than talking or can be heard snoring through doors?)			
Do you often feel TIRED, fatigued or sleepy during the day time?			
Has anyone OBSERVED you stop breathing during your sleep?			
Do you have or are you being treated for high blood PRESSURE?			

For office use:

BMI >35	
Age >50	
Neck >40cm	
Male?	

0-2, 3-4, 5-8

How many hours do you sleep most nights?

Social History

Occupation:

Marital Status: Single Married Separated Divorced Widowed

Number of Children:

Religious Affiliation (optional):

Tobacco Use:

Currently: No Yes If yes, how much per day? _____ How many years? _____

Past: No Yes If yes, how much per day? _____ How many years?_____

When did you quit?_____

Alcohol Use

In the last 6 months, how much alcohol do you consume per day or week? _____

Do you have any history of heavy alcohol use? Yes No How long ago? _____

Family History

Please indicate conditions that run in your family:

	Father	Mother	Siblings	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Diabetes							
Cancer							
Heart Disease							
Stroke							
Aneurysms							
Overweight							
Obese							
Malignant Hyperthermia							

Others Conditions (List):

Nutrition

What would you consider healthy for you? Weight in lbs:

Which of the following eating behaviors are concerns for you? Check all that apply:

- ☐ High calorie beverages (soda, sugared-coffee or sweetened beverages, etc)
- ☐ High calorie foods (fast foods, convenience foods, snack foods, sweets/desserts, etc)
- ☐ Emotional eating (anxiety/stressed/depressed eating)
- ☐ Environmental cues (social eating/drinking, food at work, lonesome/boredom eating)
- ☐ Always hungry or never hungry
- ☐ Night eating (late evening or getting out of bed to eat)
- ☐ Other comments on eating patterns, food environments, or food choices:

Which of the following diets have you tried? Check all that apply:

- ☐ Weight Watchers
- ☐ Slim Fast
- ☐ Atkins
- ☐ Nutrisystem
- ☐ Medifast/Optifast
- ☐ Profile Diet
- ☐ HCG
- ☐ Jenny Craig
- ☐ Low Fat/Low Carb
- ☐ Calorie Restricted
- ☐ Over-the-Counter Products

☐ Other diet plans (please list)_____

☐ Prescription weight loss medications? Which ones? _____

What is the most success you have had with your weight loss efforts?

How much weight was lost? _____
How long were you able to maintain the weight loss? _____

What program were you using?_____

Exercise

Do you have a current exercise routine? Yes No

If yes,

How many minutes are you exercising per week? _____

What do you do for exercise? _____

If no, have you exercised regularly in the past? Yes No

In your experience with exercise, what kinds of activity do you most enjoy?_____
Do you notice changes in your weight when you exercise regularly? Yes No
Do you have any limitations with exercise? (painful joints or back, significant heart or lung disease)
Please explain:

Stress

How would you rate your current stress level? (0 = low, 10 = high)
0 1 2 3 4 5 6 7 8 9 10

How would you rate your stress level over the last year?
0 1 2 3 4 5 6 7 8 9 10

Do you have a regular practice of prayer, meditation, or mindfulness? Y N

What other activities do you practice for stress relief?

Social Support

Do you have places or groups of people that give you a sense of belonging? Where/Who?

Who are the people in your life who inspire you to healthy living and/or live a healthy lifestyle themselves?

How supportive is your family of your weight loss efforts?
(0 = not at all supportive, 10 = extremely supportive)
0 1 2 3 4 5 6 7 8 9 10

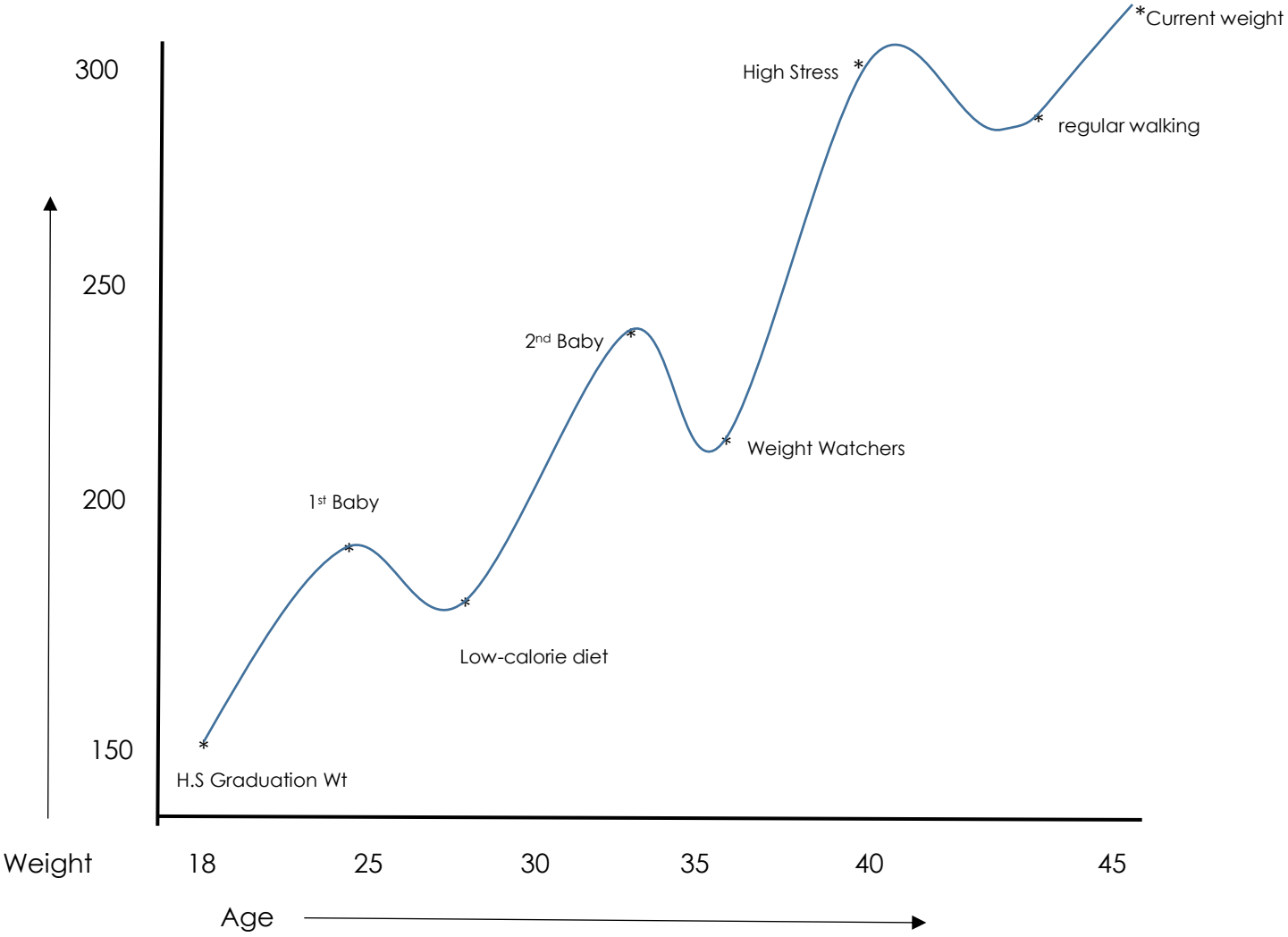
Review of Systems

Have you recently had any of the following symptoms?
Check all that apply:

- ☐ Fevers/chills
- ☐ Night sweats
- ☐ Headaches
- ☐ Visual disturbances
- ☐ Seizures
- ☐ Weakness
- ☐ Unexpected weight changes
- ☐ Chest pain with activity
- ☐ Palpitations
- ☐ Heart arrhythmias
- ☐ Excessive shortness of breath
- ☐ Abdominal pain
- ☐ Constipation/diarrhea
- ☐ Bloody stools
- ☐ Nausea/vomiting
- ☐ Bloating
- ☐ Poor oral health
- ☐ Difficulty swallowing
- ☐ Appetite changes
- ☐ Swelling of extremities
- ☐ Intolerance to heat
- ☐ Intolerance to cold
- ☐ Dry skin
- ☐ Other skin problems
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Changes in mental clarity/concentration
- ☐ Depression
- ☐ Anxiety
- ☐ Frequent illnesses
- ☐ Blood Clots
- ☐ Bleeding/clotting disorders
- ☐ Personal history of cancer

For our marketing purposes would you be open to:
Writing a testimonial about your experience? Y N Sharing before/after photos? Y N

Example graph:



For Office Use:

- ☐ Labs
- ☐ DEXA
- ☐ Metabolic Testing
- ☐ EGD
- ☐ Psych Evaluation
- ☐ Ultrasound
- ☐ Sleep Study
- ☐ Internal Med Referral