HEYDARI Health Center

Medically Managed Weight Loss and Wellness Center

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HEALTH QUESTIONNAIRE

Name: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Home Phone: ( ) ______________ Mobile Phone:( ) ______________

E-Mail: ______________________________

Occupation: ______________________________

Employer: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Phone: ______________ Ext.: ______________

Date of Birth: ______________________________

Referring Physician: ______________________________

Social Security #: ______________________________

Health Insurance: (applicable to surgery and /or counseling/therapy)

____

Principal Insurance Holder: ☐ Self ☐ Spouse ☐ Partner

☐ Other______________________________

Emergency Contact

Name: ______________________________

Address: ______________________________

____

Phone: ( ) ______________________________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Friend

☐ Other______________________________

Name: ______________________

Health Questionnaire (cont'd)

Primary Care Physician

Name: ______________________
Address: ______________________
____
____
Phone: ______________________ Fax: ______________________

WEIGHT LOSS HISTORY

Please check the appropriate boxes and add notes as needed (please be specific).
My obesity started: ☐ In childhood ☐ At puberty ☐ As an adult
☐ After pregnancy ☐ After a traumatic event
☐ ______________________

Additional notes regarding the onset of obesity: ______________________
____
____
____
____

Weight Loss Programs/Diets/Medications
(please list type and dates)

☐Medically supervised weight loss attempts: ______________________

☐Weight loss programs: ______________________

☐Diets: ______________________

Height: ______________________
Highest adult weight: ______________________ Date: ______________________
Lowest adult weight: ______________________ Date: ______________________
Most weight lost on any program: ______________________ Program Type: ______________________

Taste preferences (please check all that apply)
☐ Sweets ☐ Salty ☐ Fast food ☐ Comfort foods ☐ ______________________

Eating Habits (please check all that apply)
☐ Binge eater ☐ Stress ☐ Boredom ☐ loneliness ☐ ______________________

Name: ____________________

Health Questionnaire (cont'd)

Please list any medications to which you are **allergic:**

Medication	Reaction

Please list any **medications, vitamins and/or herbal supplements** you are presently taking:

Medication	Dosage	Time taken	Reason for Medication

Please list all **previous surgeries and hospitalizations:**

Procedure/Diagnosis:	Date	Hospital

Name: ______________________

Health Questionnaire (cont'd)

Family History
Please check which, if any, of your family members had any of the following conditions:

Condition	Sibling	Mother	Father	Grand-parent	Aunt/ Uncle	Comment
Anemia						
Bleeding Problems						
Blood Clots						
Cancer						
Diabetes						
Gallstones						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Obesity						
Sleep Apnea						
Stroke						

Obesity related conditions
(please check if you have any of the following conditions)

- ☐ Belching of sour fluid
- ☐ Coughing or choking at night
- ☐ Daytime falling asleep
- ☐ Diabetes Mellitus
- ☐ Gout
- ☐ Heartburn/esophagitis
- ☐ High Cholesterol
- ☐ Joint pain/Arthritis
- ☐ Shortness of breath
- ☐ Sleep Apnea Syndrome
- ☐ Bulimia/Excessive vomiting
- ☐ Daily Headaches
- ☐ Depression
- ☐ Gallbladder disease
- ☐ Hernia
- ☐ Hiatus Hernia
- ☐ High Blood Pressure
- ☐ Leakage of Urine
- ☐ Rash/Dermatitis
- ☐ Swollen Ankles/Feet

Habits

Are you a smoker? ☐No ☐Yes Packs/day: ______________________

Have you ever been a smoker? ☐No ☐Yes Age started:______ Age quit: ________

Do you consume alcohol? ☐No ☐Yes Drinks/day: ______________________

Do you use recreational drugs? ☐No ☐Yes Type/frequency: ________________

____

Name: ____________________

Health Questionnaire (cont'd)

Please check yes or no if you had any of the following **medical conditions** *at any time:*

Condition	No	Yes	Comment
Allergies			
Anemia			
Asthma			
Bladder/Kidney infections			
Blood transfusions			
Cancer			
Colitis or Irritable Bowel Syndrome			
Easy bruising			
Epilepsy/Seizures			
Excessive/heavy bleeding			
Fainting			
Frequent nausea			
Heart attack			
Heart failure			
Heart murmur			
Heart palpitations			
Heavy drinking			
Hemorrhoids			
Hepatitis			
Kidney Stones			
Leg-cramping			
Liver disease			
Lung disease/Pneumonia			
Migraine/severe headaches			
Rheumatic fever			
Stroke			
Thyroid trouble			
Tuberculosis			
Tumors			
Ulcers			
Varicose veins			

Women only

Date of last menstrual period: ____________________

Are your menstrual periods regular? ____________________

Are you using birth control? __________ If yes, what type: __________

Number of Pregnancies: __________ Number of live births: __________

Other comments: ____________________

Name: ______________________

Health Questionnaire (cont'd)

Exercise

Please describe your exercise routine. Include type of exercise, frequency and physical limitations.

Other Concerns

Please write any other concerns that you have regarding your health or bariatric surgery.

Please do not write below this line

OFFICE USE ONLY

Physician/Surgeon/Bariatrician Notes