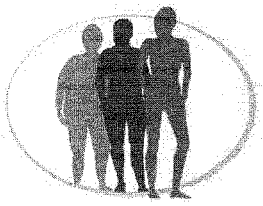

HEYDARI Health Center

Medically Managed Weight Loss and Wellness Center

Heydari Health Center
BMI WEIGHT BUSTERS, INC.
690 E Terra Cotta Ave, Suite B
Crystal Lake, IL 60014
(815) 477-2615

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