Lenox Hill Hospital
Northwell Health

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Patient Health History Questionnaire
BARIATRIC SURGERY

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

(PLEASE PRINT)

_____ /_____ /_____ DATE: _____ /_____ /_____
PATIENT: LAST NAME FIRST MIDDLE

_____ / _____ / _____ _____ _____ / _____ / _____
BIRTH DATE AGE SOCIAL SECURITY NO.

_____ _____
HOME PHONE NO. CELL PHONE NO.

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

CARDIOVASCULAR DISEASE:

Yes □ No □	Palpitations (irregular and/or forceful heartbeat)	
Yes □ No □	Varicose Veins	
Yes □ No □	Swelling of Ankles/Feet	
Yes □ No □	Blood clot (Deep Vein Thrombosis- DVT)	
Yes □ No □	Pulmonary Embolism	
Yes □ No □	High Cholesterol	
Yes □ No □	High Triglycerides	
Yes □ No □	High Blood Pressure	
Yes □ No □	Angina (chest pain)	
Yes □ No □	M.I. (myocardial infarction, heart attack)	
Yes □ No □	CABG (coronary artery bypass graft, known as open heart surgery)	
Yes □ No □	Abnormal EKG	
Yes □ No □	Shortness of breath	
Yes □ No □	Stress test to rule out cardiac problems	Date:_____
Yes □ No □	Echocardiogram (heart ultrasound)	Date:_____

DIABETES:

Yes □ No □ Diabetes

Yes □ No □ Do you take Insulin

Yes □ No □ Oral Medication

ASTHMA

Yes □ No □ Asthma

Yes □ No □ Hospitalization in last 2 years

Yes □ No □ Steroid use in last 2 years

SLEEP APNEA SYNDROME

Yes □ No □ Sleep Apnea

Yes □ No □ CPAP or BiPAP

Year diagnosed: _____

Last sleep study: _____

Yes □ No □ **HEARTBURN/ HIATUS HERNIA**

GALLBLADDER

Yes □ No □ Gallbladder disease

Yes □ No □ Gallbladder removed

Yes □ No □ Ultrasound performed

GENITO-URINARY:

Yes □ No □ Leakage of urine with laughing/coughing/ sneezing

Yes □ No □ Wear pads frequently

MUSCULOSKELETAL:

Yes □ No □ Arthritis

Yes □ No □ Low back strain/pain/sciatica

Yes □ No □ Pain in hips/knees/ankles/feet

Yes □ No □ Assistance to ambulate

Exercise limitation: (CIRCLE ONE) None / Minimal / Severe

Yes □ No □ **CANCER**

Yes □ No □ Breast

Yes □ No □ Endometrial

Yes □ No □ Uterine

Yes □ No □ Prostrate

Other: _____ Treatment/Remission:_____

Yes □ No □ **WEIGHT RELATED INJURIES AND TRAUMA**

Yes □ No □ **VENOUS STASIS DISEASE**

Yes □ No □ **COLITIS**

Yes □ No □ **LIVER DISEASE**

Yes □ No □ **ULCERS / GASTRITIS**

Yes □ No □ **RECTAL BLEEDING**

Yes □ No □ **THYROID DISEASE**

Yes □ No □ **EATING DISORDER**

If Yes, have you been seen by a specialist? Yes □ No □

For female patients only

Currently pregnant: Yes □ No □

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications:

_____

Do you presently use:

□ Birth control pills Yes □ No □ List Type: _____

□ Estrogens Yes □ No □ List Type: _____

***Current Medications**:*

Are you taking any pain killers/narcotics/opioids**? Please list all**

Aspirin	Yes □ No □
Non-Steroidal Anti-Inflammatory Drug (NSAID)	Yes □ No □
Blood Thinner (Coumadin®, Plavix®, Lovenox®)	Yes □ No □
Narcotics ie- Percocet®/Vicodin®/Oxycodone®/Tramadol®	Yes □ No □

Drug	Dosage	Frequency	Reason Prescribed

SYSTEM REVIEW

Check all symptoms which you have, or have had. Write in any additional problems.

HEAD, EYE, EAR, NOSE & THROAT:

□ STUFFY NOSE	□ RUNNY NOSE	□ HAY FEVER
□ SINUS TROUBLE	□ EARACHE	□ HEADACHE
□ BLURRY VISION	□ DOUBLE VISION	□ HALOS AROUND LIGHTS
□ LOSS OF NIGHT VISION	□ BUZZING IN EARS	□ RINGING IN EARS
□ DISCHARGE FROM EAR	□ LOSS OF HEARING	□ DIZZINESS
□ VERTIGO	□ LOSS OF BALANCE	□ SORE THROAT
□ LUMP IN THROAT	□ TROUBLE SWALLOWING	□ HOARSENESS
□ PAIN WITH SWALLOWING		

RESPIRATORY:

□ BRONCHITIS	□ WHEEZING	□ ASTHMA
□ USE TWO PILLOWS	□ BLOOD IN SPUTUM	□ OUT OF BREATH WITH EXERTION
□ COUGH	□ EMPHYSEMA	□ SHORTNESS OF BREATH AT NIGHT
□ WAKE UP AT NIGHT COUGHING OR CHOKING		□ WAKE UP AT NIGHT SHORT OF BREATH

CARDIOVASCULAR:

□ PALPITATIONS	□ POUNDING OF HEART	□ SKIPPING OF HEARTBEAT
□ PAINS IN CHEST	□ PAINS IN NECK	□ PAINS IN ARMS
□ HEART ATTACK	□ HEART MURMUR	□ SQUEEZING OF CHEST
□ COLD FEET	□ LOSS OF PULSES	□ ABNORMAL ELECTROCARDIOGRAM
□ IRREGULAR HEARTBEAT	□ HIGH BLOOD PRESSURE	□ PAIN IN LEGS
□ BLUE TOES	□ BLUE FINGER	

GASTROINTESTINAL:

□ HEARTBURN	□ NAUSEA	□ VOMITING
□ GASSINESS	□ ACID STOMACH	□ DIARRHEA
□ CONSTIPATION	□ HEMORRHOIDS	□ BELCHING FLUID IN THROAT
□ BURNING IN THROAT	□ PAINS IN STOMACH	□ FOOD STICKING IN CHEST
□ BURNING IN STOMACH	□ BLOOD IN STOOLS	□ PAIN WITH BOWEL MOVEMENT
□ FISSURES	□ CRAMPS	□ IRRITABLE COLON COLITIS

GENITOURINARY:

□ PAIN WITH URINATION	□ TROUBLE STARTING URINE	□TROUBLE STOPPING URINE
□ SMALL URINE STREAM	□ BLOOD IN URINE	□ KIDNEY FAILURE
□ NEPHRITIS	□ FREQUENT URINATION	□ URINARY TRACT INFECTIONS
□ KIDNEY STONES	□ GETTING UP AT NIGHT TO URINATE	
□ LEAKAGE OF URINE WITH COUGH OR SNEEZE		

MEN:

□ DISCHARGE FROM PENIS □ LOSS OF ERECTION □ PAINFUL ERECTION

OB/GYN:

□ VAGINAL DISCHARGE □ VAGINAL BLEEDING

□ PAIN WITH INTERCOURSE □ IRREGULAR PERIODS

ENDOCRINE (GLANDULAR):

□ LOW THYROID □ HYPERTHYROID □ GOITER

□ GRAVE'S DISEASE □ THYROID NODULES

□ DIABETES □ ADRENAL GLAND TUMOR □ FREQUENT FLUSHING

□ FREQUENT HEAVY SWEATING

MUSCULOSKELETAL:

□ PAIN IN JOINTS □ SWELLING OF JOINTS □ WARM JOINTS

□ FLUID IN JOINTS □ ARTHRITIS □ BROKEN BONES

□ SPRAINS □ LOW BACK PAIN □ SCIATICA

□ HIP PAIN □ KNEE PAIN □ ANKLE PAIN

□ FOOT PAIN □ FLATFEET □ SLIPPED DISK

□ HERNIATED DISK □ REDNESS OF SKIN OVER JOINTS

NEUROLOGICAL:

□ DIZZINESS □ VERTIGO □ FALLING TO THE SIDE

□ FALLING AT NIGHT □ NUMBNESS □ TINGLING

□ SHAKINESS □ PINS & NEEDLES FEELINGS □ WEAKNESS OF ANY MUSCLES

□ TWITCHING OF MUSCLES □ WEAKNESS OF GRIP □ TREMOR

□ FAINTING □ CONVULSIONS □ FITS

□ LOSS OF CONSCIOUSNESS

PSYCHOLOGICAL:

□ NERVOUSNESS □ DEPRESSION

□ PSYCHOLOGICAL COUNSELING □ THOUGHTS OF SUICIDE

□ SUICIDE ATTEMPTS □ PSYCHIATRIC TREATMENT

□ HOSPITALIZATIONS FOR EMOTIONAL PROBLEM □ANXIETY

FAMILY HISTORY

Please indicate if there is a family history of:

□ Obesity
□ Diabetes
□ High blood pressure
□ Heart disease
□ High blood cholesterol
□ Lung disease, asthma or emphysema
□ Kidney disease
□ Bleeding tendency or blood disorder
□ Breast cancer
□ Colon cancer

SOCIAL HISTORY

Marital Status: S: ___ M: ____ D: ____ W: ____ Religion: _____

Level of Education: _____

Persons Living in the Home:_____

Smoking History: Never □ Former Smoker □ Year Quit: _____

CURRENTLY Smoking OR Vaping : Yes □ No □

Number of packs per day:_____ Number of years:_____

Are you willing to quit? Yes □ No □

Recreational Drug Use: Yes □ No □ Describe:_____

Alcohol Intake Yes □ No □

Frequency of alcoholic beverages: None □ Light □ Moderate □ Heavy □

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	**Age**	**Weight**
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

Weight Loss Attempts

Method	Yes	# Months	Year	# of Pounds Lost	Wt Regained
Weight Watchers					
Jenny Craig					
Nutri-Systems					
Opti/Medi Fast					
Phen Fen/Redux					
Phentarmine					
Meridia					
Xenical / Orlistat					
Ephedra					
Metabolife					
Nutritionist					
Slim Fast					
Atkins					
South Beach					
Overeaters Anonymous					
Weight Loss Camp					
Medically Supervised Wt Loss					
Doctor Prescribed Diet					
Hypnosis					
Acupuncture					
List any other wt loss attempt(s)					

Previous weight loss surgery Yes □ No □

Date of Surgery: _____ Name of Surgeon: _____

Name of operation: _____Wt at Operation:_____Max Amt Wt Lost:_____

Please list any other information you feel is important for your Dietitian:

_____

_____

_____

The above is true and correct to the best of my belief

Print Patient Name:_____ Patient Signature:_____

Date: _____

Surgeon: _____ Date Reviewed with Patient: _____

Surgeon Signature: _____

Dear our “Future Weight Loss Warrior,”

The Registered Dietitians will be working with you throughout your journey to success. We call it a personal journey because we will be working closely together in achieving your every goal. In order to better assist you with your individual needs, we ask that you carefully fill out the following paper work in **DETAIL**. We want to know who you are, and what your habits are like, so together we can create a plan that works best for you. This is not a diet!! This is a lifestyle. Only with the proper information can we provide a plan that will get you to where you want to be, both physically and emotionally.

If any pages of these packets are skipped, it will delay comprehensive service.

Looking forward to meeting you!

NUTRITION HISTORY

Name: _____ **Age**: _____ **DOB:** _____

Occupation: _____

Ht: _____ **Wt:** _____ **BMI**:_____ **IBW**:_____

What were the 2 most effective diets and why?

1. _____ 2. _____

Why? _____

Have you seen a nutritionist is the past? □ **Yes** □ **No**

What is the most weight lost on a diet? _____

How? _____

EXERCISE HISTORY

Exercise	Described	Frequency	Duration	Time

FOOD REFERENCES

Indicate which foods you prefer (which food would most likely make you go off a diet)

Candy _____	Chips/Snacks _____	Seafood _____
Chocolate_____	Fried Food _____	Dairy _____
Cakes/Pies _____	Fast Food _____	Red Meat _____
Cookies _____	Pizza _____	Poultry _____
Ice Cream _____	Bread _____	Vegetables _____
	Cold Cereal _____	Fruit _____

Cravings/Favorites Foods:

_____

_____

__

Food Allergies:

_____

FOOD PATTERN: **Number of Meals per day**? _____ **Eat between meals:** □ **Yes** □**No**

TYPICAL DIET- When NOT dieting-Current? □Yes □No

Breakfast:	**Snack**	**Lunch**	**Snack**	**Dinner**	**Snack**
				__2nd/3rd helping	

Fast Food/ Restaurants: _____ #Wk: **Give an example of a typical meal if you order from**

Chinese/Asian Cuisine
Spanish/Mexican
French/Italian/Pizza
Steakhouse/Seafood
American/Dinner/Deli/Cafeteria
McDonalds/Burger King/Wendy's
Other:

Binges/Trigger Foods/Environmental Triggers:

EATING HABITS AND EMOTINAL EATING SELF-ASSESSMENT **Eat In Response to:**

____ Skip Meals/Erratic Meal times ____ Secret eating ____ Binge eating (feel out of control/Guild) ____ Night eating ____ Eat while doing/TV/Cooking/Work ____ Eat fast/ don't chew well ____ Clean plate ____ 2nd Helping often ____ Meal Eater ____ Grazer/snacker btw meals	___ Dine out > 2x per week ___ Large Portions ___ Frequent Snacks/grazing ___ Eat until stuffed/uncomfortable ___ Usually hungry at meals/snacks ___ Rarely/hungry at meals/snacks ___ Not satisfied after meals-still hungry ___ Sweets/bake goods ___ Salty, crunchy snacks ___ Savory Meals foods	___ Depression ___ Anger ___ Habit/"time to eat" ___ Bored/" because is there" ___ Lonely ___ Worry/stressed/anxious/nervous ___ Reward/celebratory ___ Relaxation/Escape ___ Hunger ___Craving w/o hunger

What do you feel are your personal diet and behavioral dies obstacles for losing weight and maintaining weight loss:

_____

_____

_____

_____

How much weight would like to lose from WLS?

_____ What do you feel is your ideal weight? _____

<u>Diet and Behavioral Self Recommendations:</u>

1. Read food labels/practice portion control
2. Make lower fat choices: Avoid fried/fast food-alt. cooking methods/food choices
3. Avoid beverages with calories and carbonation; reduce caffeine intake
4. Exercise 30minutes brisk walking most of day of the week

5. Time management and meal planning
6. Avoid bringing trigger/binge foods into the home of workplace
7. Other: _____

The above is true and correct to the best of my belief **Print Patient Name**:_____

Patient Signature: _____ **Date**_____