

BARRINGTON BARIATRIC CENTER

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~ The Path to a Healthier Lifestyle ~

Health History Questionnaire

This Health History Questionnaire is designed to help us understand your medical history and customize a weight loss program especially for you.

Patient's Name: _____
Last Name First Name Middle Initial

Social Security Number (SSN#): _____

Home Address: _____

City/State/Zip Code: _____

Date of Birth: _____ Age: _____ Sex: ___ Male ___ Female

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Other (____) _____

Best number to be reached during the day Home Work Cell Other

Email: _____

Occupation: _____

Current Weight: _____ Height _____

Which procedure are you interested in? Gastric Band Gastric Bypass

How did you first hear about BARRINGTON BARIATRIC CENTER (please circle all that apply)?

Friend Family Doctor TV Radio Newspaper Internet Other _____

Did you hear about us from your doctor? If yes, please list the name, phone number, address and specialty of this doctor.

Name: _____ MD or DO

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Physician Information: Please list all doctors that you have seen and helping in your care:

Name: MD, DO, NP	Address	Phone	Specialty	Do you want us to send an update letter(s) to this MD about your involvement in our program?

Date of Last Annual Physical exam with your doctor: _____

Medications

Please list your current medications including: inhalers, birth control pills/shots, over-the-counter medications, vitamins, minerals and herbal supplements:

Name	Dosage	How frequently do you take this medication in a day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any Allergies? Yes No

Please list _____

Have you been on any kind of steroids in the last 12 months? Yes No

Please list _____

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Weight/Diet History

1. At what age did you start to become overweight? _____
2. What was your weight ranges between the ages of 15 and 20? Minimum ____ Maximum ____
3. What has been your weight during the past 5 years? Minimum ____ Maximum ____
4. What has been your weight during the past 1 year? Minimum ____ Maximum ____
5. What has been the maximum weight you have ever weighed? _____
6. Please circle how many times have you tried an unsupervised (those that you do on your own) diets in your life? Try to make an educated guess if you do not know the exact amount of times.

0 1-5 6-10 11-25 26-50 50-100 >100

Please list all diet programs you have done in the past 5 years

Diet Program	Year and Duration (i.e. 3 month)	Total Weight Loss	Pounds gained	Documentation Available?
<i>EXAMPLE DIET</i>	<i>1996 – 6 months</i>	<i>10 pounds</i>	<i>16 pounds gained back</i>	<i>Yes</i>
Dietician				
Phen-Fen				
Redux				
Meridia				
Fasting				
Nutra Systems				
Jenny Craig				
Overeaters anonymous				
Seattle Sutton				
Metabolife				
Weight Watchers				
Optifast				
Atkins				
Slimfast				
Hypnosis				

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Other Programs: (List Here)

7. What is the most weight you have lost during any diet program? _____
8. How many meals do you consume per day? _____ How many snacks? _____
9. Do you prefer sweets over other types of food? Yes No
Other _____
10. Do you have any food allergies? Yes No If yes, please list _____

11. Do you: Over eat Over Indulge or binge eat?
(Over eating is when you plan to eat a normal amount and you overeat but not to the point of feeling like you may vomit. Over indulgence is when you plan to eat too much but not to the point of wanting to vomit. Binge eating is defined as eating a large amount of food during a short period of time, typically no more than 2 hours, **while feeling out of control to stop eating.**)
12. Do you purge (make yourself vomit after a meal)?
Yes No If yes, how often? _____
13. How many soft drinks do you consume per day? Diet _____ Regular _____
14. How many cups of coffee do you consume per day? ___ cups of tea? ___ cups
Do you add: sugar artificial sweeteners creamer
15. Do you consume (drink) alcohol? Yes No If yes, how often? _____
16. How much water do you drink per day? _____

Exercise History

17. Do you exercise routinely? Yes No
If yes:
Frequency (how often) _____
Intensity: circle one light somewhat hard hard {heavy} very hard
Time (minutes) _____
Type (walk, bicycle, etc.) _____
How long have you been doing this program? _____

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18. If you do not exercise, what is your primary limitation that makes exercise difficult?

- Lack of Time
- Lack of Motivation
- Lack of access to equipment
- Physical pain (please describe) _____
- Other (please describe) _____

19. What exercise equipment do you have available? Circle all that apply.

Treadmill Stationary Bike Rowing Machine Pool Elliptical Gazelle
Aerobics Videos Other: _____

Fitness Center Membership Yes No
Curves Membership Yes No

20. How far can you walk without having difficulty? < 1 block <1/2 mile <1 mile >1 mile

When you go past this distance, what limits your ability to continue? _____

Please rank the these in terms of severity (0→5) with zero being minimal and "5" being severe.

Shortness of breath _____
Chest pain _____
Fatigue or tired _____
Muscular pain in calf or thigh _____
Pain in joints (which ones) _____
Other _____

How many stairs can you climb without difficulty? _____

21. Do you currently smoke? Yes No If yes, how many cigarettes per day? _____
If yes, how long have you been smoking? _____yrs

22. Have you ever smoked? Yes No if yes, how long ago did you quit? _____

Psychological History

23. Have you seen a mental health professional such as a psychiatrist or psychologist for treatment in the last 2 years? Yes No

Have you been hospitalized for a psychiatric condition in the last 2 years? Yes No

If yes, please describe: _____

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24. In the past two years have you:

- Experienced severe anxiety or panic attacks? Yes No
- Experienced feelings of depression? Yes No
- Been on any medications for depression, anxiety, or other Psychological reasons? Yes No

If yes, please list those medications: _____

OB-GYN History

25. If female, please answer the following questions.

- How many times have you been pregnant? _____
- How many live births? _____
- Do you have Polycystic Ovarian Syndrome? Yes or No
- d. After childbirth, has your weight: increased stayed the same decreased
- What type of birth control method do you use? _____
- If you are pre-menopausal, do you have any problems with your periods? (Note, if you are on birth control pills or shots to regulate your periods check yes) Yes No
- If yes, please circle: Heavy Painful Irregular
- Describe _____
- If you are post menopausal are you on hormone replacement therapy? Yes No
- Have you ever had problems with infertility? Yes No
- Please give the last date(Month/Year) had the following exams:
Pelvic exam ___/___ Breast exam ___/___
Mammogram ___/___ Pap Smear ___/___

If any were abnormal, please explain: _____

Family History

26. What percentage of people on your mother's side of the family are overweight? _____%

27. What percentage of people on your father's side of the family are overweight? _____%

28. Does anyone in your **family** have the following:

Disease	Circle	Relationship	Notes
Diabetes	Yes No		
Thyroid	Yes No		
Adrenal	Yes No		
Heart	Yes No		
Hypertension	Yes No		
Abnormal Cholesterol/Triglycerides	Yes No		
Cancer	Yes No		
Bleeding or Clotting disorders	Yes No		
Other major diseases	Yes No		

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Please circle the appropriate response and answer all questions completely.

Yes No Have you seen another Physician at Advanced Surgical Care _____

Yes No Do You smoke? If yes, how much per day? _____
If you have quit smoking, when did you quit? _____

Yes No Do you have high Blood Pressure? Lists meds: _____

Yes No Do you take medication for arthritis? Lists meds: _____

Yes No Do you have joint pain? Back Hips Knees Ankles Feet

Yes No Do you have Diabetes? Insulin? _____ Other meds: _____

Yes No Do you have chronic and/or severe headaches?

Yes No Do you wake up with a headache?

Yes No If you are a menstruating female, do you have irregular/abnormal cycles?

Yes No Do you leak urine when you cough, sneeze, or laugh?

Yes No Have you ever been treated for a stomach or duodenal ulcer?

Yes No Have you been diagnosed with: HIV AIDS Hepatitis B Hepatitis C

Yes No Do you Snore?

Yes No Have you ever been told that you stop breathing when you sleep?

Yes No Have you ever fallen asleep at the wheel?

Yes No Do you have to take a nap every day?

Yes No Do you feel rested when you make up in the morning?

Yes No Do you wake up (from a deep sleep) choking or coughing?

Yes No Have you ever been told you have sleep apnea? Do you use c-pap or bi-pap?

Yes No Do you drink alcoholic beverages? What type and how often? _____

Yes No Do you, or have you ever been to a psychologist or psychiatrist?
Name: _____ Reason _____
List any medications _____

Yes No Have you ever been hospitalized for depression, anxiety or related issues?
When _____ Where _____

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Yes No Do you have heartburn? If yes, how often does it happen?

Less than once a week _____ 1-2 times per week _____

3-4 times per week _____ 5 or more times a week _____

Yes No Do you take medication for heartburn or reflux? Lists meds: _____

Yes No Do you take medication for cholesterol or triglycerides? Lists meds _____

Yes No Do you have swellings in your legs?

Yes No Have you ever had an ulcer or non-healing sores on your legs?

Yes No Do you have shortness of breath or trouble breathing?

Yes No Do you have chest pain when you exert yourself (walk, climb stairs, etc)?

Yes No Have you ever seen a Cardiologists?

Yes No Have you ever had a heart attack or any other heart problems? If yes, please list any Physicians, date of workup, test done, and findings.

Yes No Have you ever had surgery for weight loss? Surgeon name _____

Surgical History

Type of Surgery	Date	Reason for Surgery