SCHNECK
Better Healthcare Begins Here

PATIENT HEALTH QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete, detailed responses. Don't forget to bring this completed form with you to your first appointment. If you have any questions, please contact Schneck Bariatrics at 812-523-5230.

Today's date: _____

First name: _____ Last name: _____

Gender: ☐ Female ☐ Male Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail address: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse name: _____

Do you have a belief system or religion that would interfere with receiving some or all of the recommended treatments for this program? If so, please disclose your religion: _____

Patient employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer phone & direct extension: _____

Spouse's employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency contact: _____ Relation: _____

Phone number: _____ ☐ Home ☐ Cell Phone

Please indicate if you have the following: ☐ Living Will ☐ Durable Power of Attorney

Family doctor: _____ Phone number: _____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight: _____

Patient Name_____

Dietary History

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

			Date(s)	Duration	MD Supervised (circle one)		Max Loss
Jenny Craig	☐ Yes	☐ No			☐ Yes	☐ No	
Nutri-Systems	☐ Yes	☐ No			☐ Yes	☐ No	
Weight-Watchers	☐ Yes	☐ No			☐ Yes	☐ No	
Opti/Medi Fast	☐ Yes	☐ No			☐ Yes	☐ No	
Fen/Phen/Redux	☐ Yes	☐ No			☐ Yes	☐ No	
Meridia	☐ Yes	☐ No			☐ Yes	☐ No	
Atkins	☐ Yes	☐ No			☐ Yes	☐ No	
T.O.P.S.	☐ Yes	☐ No			☐ Yes	☐ No	
Curves	☐ Yes	☐ No			☐ Yes	☐ No	
South Beach	☐ Yes	☐ No			☐ Yes	☐ No	
Cutting Calories / Low Fat	☐ Yes	☐ No			☐ Yes	☐ No	

List all other diets and/or weight loss attempts: _____

_____

Lowest weight in past 5 years: _____ Highest weight in past 5 years: _____

Food Preferences

Indicate which foods would most likely make you go off a diet:

☐ candy ☐ ice cream ☐ cakes/pies ☐ steaks/chops ☐ pizza

☐ potatoes ☐ fried foods ☐ salad dressings ☐ pasta ☐ soda/soft drinks

☐ chips/snacks ☐ french fries ☐ cookies ☐ chocolate

Which surgery are you considering?

☐ LapBand ☐ Gastric Bypass ☐ Gastric Sleeve ☐ Duodenal Switch

Weight-Related Illnesses

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

		Provider Comments
1. Heart Disease Year diagnosed: _____	☐ Yes ☐ No	
2. High Cholesterol	☐ Yes ☐ No	

Patient Name_____

3. High Blood Pressure	☐ Yes ☐ No	
4. Diabetes	☐ Yes ☐ No	
5. Asthma	☐ Yes ☐ No	
6. Depression	☐ Yes ☐ No	
7. Anxiety	☐ Yes ☐ No	
8. Sleep Apnea Syndrome Setting:_____ Last sleep study(month/year): CPAP used Setting:_____ Morning headaches Excessive Daytime drowsiness Restless sleep Snoring Awakenings at night Observed apneic episodes	☐ Yes ☐ No _____ ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	*Sleep study ordered.*_____ *(initials)*
9. History of Eating Disorders	☐ Yes ☐ No	
10. Heartburn/Esophagitis/Hiatus Hernia	☐ Yes ☐ No	
11. Gallbladder Disease	☐ Yes ☐ No	
12. Leakage of Urine with laughing/ coughing/sneezing	☐ Yes ☐ No	
13. Low Back Strain/Pain/Sciatica	☐ Yes ☐ No	
14. Pain in Weight Bearing Joints	☐ Yes ☐ No	
15. Walk unassisted If **no**, do you use a: cane walker wheelchair	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
16. Swelling in Legs	☐ Yes ☐ No	
17. Thyroid Disease Are you presently taking medications?	☐ Yes ☐ No ☐ Yes ☐ No	
18. Irregular Periods or Infertility (for female patients only) If **yes,** please explain: _____	☐ Yes ☐ No _____	
19. History of repeated Skin Infections	☐ Yes ☐ No	
20. History of Blood Clots	☐ Yes ☐ No	

Patient Name_____

Exercise

What type of exercise/activity do you perform routinely (if applicable)?

Type of Exercise	Duration (how long each time)	Frequency (times per week)	Provider Comments

Health History

Please list below all serious illnesses, surgeries, and hospitalizations you have experienced.

Major illness	Date	Treatment

Major Surgery	Date	Open or Laparoscopic

Do you use tobacco? ☐ Yes ☐ No Frequency_____

Are you willing to quit? ☐ Yes ☐ No

* Please note: the Surgical Weight Loss Center will be performing random nicotine screenings on smokers.

Do you use alcohol? ☐ Yes ☐ No Frequency_____

Do you use illegal substances? ☐ Yes ☐ No Frequency_____

Medication Allergies: ☐ Yes ☐ No

If **yes**, please list medication and reaction: _____

_____

Surgical Tape / Suture Allergies: ☐ Yes ☐ No If **yes**, please list reaction._____

Latex Allergies: ☐ Yes ☐ No If **yes**, please list reaction._____

Patient Name_____

Current Medications

Please list **ALL** medications you currently use, including dose, frequency, and reason for use. Please be accurate and use your prescription bottles to assist you with the spelling.

Medication	Dose and Frequency	Reason

Physician Information

Please list all the physicians whose care you are under:

	First Name, Last Name	Address/City/State/Zip	Telephone
Primary Care Physician			
Internist			
Gynecologist			
Orthopedist			
Psychiatrist/ Psychologist			
Therapist			
Cardiologist			
Other			