

COMPREHENSIVE HEALTH QUESTIONNAIRE

NAME _____ AGE _____ BIRTHDATE _____

ADDRESS _____ GENDER F/M

_____ MARITAL STATUS _____

HOME PHONE _____ WORK PHONE _____

HEIGHT _____ WEIGHT _____

EMPLOYMENT _____ INSURANCE _____

SUBSCRIBER # _____ GROUP # _____
(Please attach a copy of your health insurance card)

IS THERE ANY REASON WHY YOU CANNOT ACCEPT BLOOD TRANSFUSIONS? _____

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES (include over-the-counter drugs)

DRUG

DOSAGE

LIST ANY HERBAL PREPARATIONS YOU HAVE TAKEN IN THE LAST 6 MONTHS:

LIST ANY WEIGHT-LOSS MEDICATIONS YOU HAVE TAKEN (Prescribed and OTC):

ALLERGIES:

SMOKING HISTORY _____

HOW MUCH ALCOHOL DO YOU CONSUME? _____

HAVE YOU BEEN TREATED FOR ALCOHOL, DRUG, TOBACCO OR FOOD ADDICTION?

COMPLETE SURGICAL HISTORY:

HISTORY OF ANESTHESIA-RELATED PROBLEMS? (nausea, vomiting, etc.)

ARE YOU KNOWN TO HAVE OR HAVE YOU BEEN TREATED FOR: (circle all that apply)

DIABETES
OBSTRUCTIVE SLEEP APNEA
GASTROESOPHAGEAL REFLUX
GALLSTONES
INFERTILITY
PEPTIC ULCER DISEASE
CANCER
CIRRHOSIS/OTHER LIVER DISEASE
HIV/AIDS

HIGH CHOLESTEROL
HIGH BLOOD PRESSURE
CORONARY ARTERY DISEASE
PSYCHIATRIC ILLNESS
DEGENERATIVE ARTHRITIS
FIBROMYALGIA
ADDICTION
DEPRESSION/ANXIETY

Please provide a detailed history of your weight problem, your attempts at weight loss and the difficulties you have encountered.

What are your goals and expectations of Weight Loss Surgery?

How have you learned about Weight Loss Surgery?