New Patient Questionnaire

Name________________________________ Clinic #:_________________ Date: _____________
Last First MI

Date of Birth:_____________ Age:________ Sex: ___M___F Ethnicity/Race: _____________

How were you referred to us (friend, physician, internet, etc)?____________________________

Primary Care Physician's Name: ____
Address: ____
Phone/Fax: ____

Past Medical and Surgical History: (please check any medical problems, current or past)

______ Heart Disease - If yes: a. Have you ever had a heart attack? ___Y ___ N
b. Have you ever had cardiac bypass surgery? ___Y ___ N
c. Have you ever had a stent placed? ___Y ___ N
______ Congestive Heart Failure
______ Cardiac arrhythmia (such as atrial fibrillation)
______ High Blood Pressure/Hypertension (# of BP medications you are taking? ____)
______ Pre-hypertension
______ High Cholesterol (On medication for it? ___Y ___ N)
______ Stroke or TIA (mini-stroke)
______ Heart Valve Disorder (Type? ____)
______ Diabetes (On Insulin? ___Y ___ N) or Pre-Diabetes/Borderline Diabetes
______ Gestational Diabetes
______ Low Testosterone / Hypogonadism
______ Polycystic Ovarian Syndrome (PCOS)
______ Thyroid Disease
______ Asthma (on oxygen at home? ___ Y ___ N)
______ COPD (on oxygen at home? ___ Y ___ N)
______ History of pulmonary embolism
______ History of DVT (deep venous thrombosis) - blood clot in leg
______ Gastric Reflux (GERD) / Heartburn (On medication for it? ___Y ___ N)
______ Stomach Ulcers
______Gallbladder Disorder
______ Osteoarthritis / Degenerative Joint Disease (Location? __________________)
______ Osteoporosis
______ Gout
______ Sleep Apnea (on CPAP or BiPAP? ___Y ___ N; when was it started?_____)
______ Cancer (Type:_________)
______ Anemia
______ Kidney Disease (Are you on hemodialysis? ___ Y ___ N)
______ Liver Disease / Fatty Liver
______ Feet or Leg Swelling / Venous Stasis
______ Migraines/Headaches
______ Glaucoma

Others: ____

Name:___________________ Clinic #:________________

Mental Health History: (please check any mental health problems, current or past)

____ Anxiety	____ Alcoholism	____ Anorexia
____ Depression	____ Drug Addiction	____ Binge Eating Disorder
____ Bipolar Disorder	____ Schizophrenia	____ Bulimia
____ Panic Attacks	____ Stress	____ Night Eating Disorder

Surgeries: (including any previous obesity surgeries)

Surgery: ____Date: _______
Surgery: ____Date: _______
Surgery: ____Date: _______
Surgery: ____Date: _______
Surgery: ____Date: _______
Surgery: ____Date: _______

Gynecologic History: (For women only)

Pregnancies: Number: ______________ Dates: _____________________________
Natural Delivery or C-Section (specify): _______________________________________
Menstrual Periods:
Age of onset: _______________________ Average length: ______________
Are they regular? Yes___ If no, explain _____________________________
Date of last menstrual period: ______
Pain associated with period: Yes___ No___
Have you had a hysterectomy? No___ If yes, why? __________________
Hormone replacement therapy: No___ If yes, type: __________________
Birth control pills: No___ If yes, type: ______________________________
Date of last pelvic exam and Pap smear: _____________________________

Medications (Prescription and Non-Prescription):
(including vitamins, minerals, or nutritional/herbal supplements)

Name	**Dose (mg)**	**Frequency (i.e. once daily, twice daily)**

Are you on any blood thinners or anticoagulation? ___ Y ___ N
Are you on steroids or other immunosuppressants for a chronic condition? ___ Y ___ N

How often do you ***forget*** to take your medication? ____________________

Do you have allergies to any medications? No___
If yes, what medication(s)? ____

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Social History:

1. Circle the last year of school attended:

   1 2 3 4 5 6 7 8 (Grade School) 9 10 11 12 (High School) 1 2 3 4 (College) ____________ (Other/Graduate School)

2. Describe your present occupation: ____

   Full time:___ Part time:___ Work hours: ____

3. Present relationship status (please circle one):

   SINGLE MARRIED PARTNERED DIVORCED SEPARATED WIDOWED

4. Number of persons who live in your household (including yourself):________

Name	Age	Relationship to you	Supportive (Y/N)	Overweight (Y/N)
______________	________	____________________	______________	_______________
______________	________	____________________	______________	_______________
______________	________	____________________	______________	_______________
______________	________	____________________	______________	_______________
______________	________	____________________	______________	_______________
______________	________	____________________	______________	_______________

5. Do you currently smoke? No___ Yes___, how many years have you been smoking ________ and how many packs per day? _________________________

6. Have you smoked in the past? No___ Yes ____, how many total years __________, how many packs per day ___________________, and when did you quit? _______________________

7. Do you drink alcohol? No___. Yes___ (what, how much, how often?__________________)

Family History: (please record only persons ***biologically*** related to you):

	Living or Deceased	Current Age or Age Deceased	Current Health or Cause of Death	Overweight(Y/N)
Father:	________	_____________	_____________	_____________
Mother:	________	_____________	_____________	_____________
Brother:	________	_____________	_____________	_____________
Brother:	________	_____________	_____________	_____________
Sister:	________	_____________	_____________	_____________
Sister:	________	_____________	_____________	_____________

Has any ***blood relative*** ever had any of the following?

High Blood Pressure:	Yes	No	Who: ____
Kidney Disease:	Yes	No	Who: ____
Diabetes:	Yes	No	Who: ____
Psychiatric Disorder:	Yes	No	Who: ____
Heart Disease:	Yes	No	Who: ____
Stroke:	Yes	No	Who: ____
Cancer:	Yes	No	Who: ____
Other:	Yes	No	Who: ____

Name:___________________ Clinic #:________________

Review of Systems: (Please check any problems you have had over the last month)

______ Nausea	______ Heat Intolerance	______ Painful Urination
______ Vomiting	______ Headaches	______ Bloody Urine
______ Sinus Pain	______ Dry Skin	______ Shortness of Breath
______ Fever	______ Brittle Hair or Nails	______ Snoring
______ Cough	______ Irregular Heart Beats	______ Frequent Urination
______ Chills	______ Weakness	______ Increased Hunger
______ Chest Pain	______ Joint Pain	______ Increased Thirst
______ Constipation	______ Arm Pain	______ Numbness or Tingling
______ Diarrhea	______ Leg Pain	______ Skin Rash
______ Dizziness	______ Abdominal Pain	______ Fatigue
______ Blurry Vision	______ Pelvic Pain	______ Hair loss
______ Nose Bleeds	______ Hemorrhoids	______ Acid reflux/heartburn
______ Neck stiffness	______ Rectal Bleeding	______ Other:______________
______ Cold Intolerance	______ Back Pain	______ Other:______________

Physical Activity:
Do you participate in regular physical activity? ___Yes ___No

If yes, what is your activity Level: **(answer only one)**

- ___ Inactive - no regular physical activity with a sit-down job
- ___ Light activity - no organized physical activity during leisure time
- ___ Moderate activity - occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling
- ___ Heavy activity - consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
- ___ Vigorous activity - participation in extensive physical exercise for at least 60 minutes per session 4 times per week

Type of Activity	How Often	How Long
_____________________	____________________________	________________________
_____________________	____________________________	________________________

If no, what obstacles are interfering with activity? ____

Functional Health Status: (check one)

Are you: Independent? ___
Partially Dependent? ___
Fully Dependent? ___

Is your ability to walk limited most or all of the time? ___ Y ___ N

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Goals and Attitudes:

1. Put an X on the line to show how ***important*** it is for you to make lifestyle changes:

…………………………………………………………………………………………..………

0	5	10
Not important	Somewhat important	Very important

2. Put an X on the line to show how ***ready*** you are to make lifestyle changes:

…………………………………………………………………………………………..………

0	5	10
Not ready	Somewhat ready	Very ready

3. Put an X on the line to show how ***confident*** you are that you can make lifestyle changes.

…………………………………………………………………………………………..………

0	5	10
Not confident	Somewhat confident	Very confident

4. What lifestyle changes would you be willing to make today? ____________________________
____

5. How much time would you be willing to spend each day on making lifestyle changes? ______
____

6. What things might make it hard for you to make lifestyle changes? ____________________
____

7. Put an X on the line to show your current level of ***stress***:

……………………………………………………………………………………………

0	5	10
Very relaxed	Managing OK	Very stressed

8. What are the main stressors in your life (i.e. work, marriage, family, boredom)? ___________
____

9. What strategies do you use to address these stressors? _____________________________
____

Obstructive Sleep Apnea Screening Questionnaire:

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   ___ Yes ___ No
2. Do you often feel tired, fatigued, or sleepy during the daytime?
   ___ Yes ___ No
3. Has anyone observed you stop breathing during your sleep?
   ___ Yes ___ No
4. Do you have or are you being treated for high blood pressure?
   ___ Yes ___ No
5. Is your BMI more than 35 kg/m^2? (can be answered by physician)
   ___ Yes ___ No
6. Is your age greater than 50 years old?
   ___ Yes ___ No
7. Is your neck circumference greater than 17in (male) or 16in (female)? (can be answered by physician)
   ___ Yes ___ No
8. Are you a male?
   ___ Yes ___ No