J. Ellner, MD, FACS

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PATIENT HISTORY 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 answers. Please be thorough. Blue or black ink only, please.

Name:		Date:	
Age:	Gender: Male Female	Occupation: (If retired, what did you do?)	
	Your Measurement	Phone Consult Measurement	Pre-Operative Measurement
Actual Body Weight			
Height			
Ideal Body Weight			
Excess Body Weight			
Target Weight			
Body Frame Small Medium Large		BMI: Waist: Hips:	BMI: Waist: Hips:

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		

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

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DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program			Dates	Duration	MD Supervised?	Max Loss
Jenny Craig	Yes_	No_				
Nutri-Systems	Yes_	No_				
Weight Watchers	Yes_	No_				
OptiFast	Yes_	No_				
Medi Fast	Yes_	No_				
Fen/Phen/Redux	Yes_	No_				
Meridia	Yes_	No_				
Lindora	Yes_	No_				
T.O.P.S.	Yes_	No_				
O.A.	Yes_	No_				
Acupuncture	Yes_	No_				
Metabolife	Yes_	No_				
Atkins Diet	Yes_	No_				
Pritikin Diet	Yes_	No_				

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1	Year_____	Weight at start_____	at delivery_____
Pregnancy #2	Year_____	Weight at start_____	at delivery_____
Pregnancy #3	Year_____	Weight at start_____	at delivery_____
Pregnancy #4	Year_____	Weight at start_____	at delivery_____

FOOD PREFERENCES

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

Rank each selection from 1 - like very much to 4 - don't care.

_____Soda/Soft drinks	_____French fries	_____Chips/snacks
_____Steaks/chops	_____Candy	_____Potatoes
_____Chocolate	_____Pasta	_____Cookies
_____Pizza	_____Cakes/pies	_____Salad dressings
_____Fried foods		

WEIGHT RELATED ILLNESSES

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

1. Heart Disease Yes_ No_
   If Yes, Year Diagnosed _____
   Do you have, or have you had:
   _ Angina
   _ M.I. (myocardial infarction, "heart attack")
   _ CABG (coronary artery bypass graft)
   _ Abnormal EKG
   _ Stress test to rule out cardiac problems
   _ Palpitations
2. High Cholesterol Yes_ No_ High Triglycerides Yes_ No_
   If Yes, Year Diagnosed _____
   List medications _____
3. High Blood Pressure Yes_ No_
   If Yes, Year Diagnosed _____
   List medications _____
4. Diabetes Yes_ No_
   If Yes, Year Diagnosed: _____
   Gestational: Yes_ No_
   Neuropathy: Yes_ No_
   Controlled with: _ Diet
   _ Oral Medication (list) _____
   Last fasting blood sugar: _____
5. Asthma Yes_ No_
   If Yes: Year Diagnosed: _____
   ER visits/last 2 yrs: _____
   Hospitalizations last 2 years: _____
   Steroids last 2 years: Yes_ No_
6. Shortness of breath Yes_ No_
   If Yes, : Can walk _____blocks
   Stairs: _____ flights
7. Trouble Sleeping? Yes_ No_
   Morning headaches Yes_ No_
   Daytime drowsiness Yes_ No_
   Restless sleep Yes_ No_
   Snoring Yes_ No_
   Awakenings at night Yes_ No_
   Observed apneas Yes_ No_

Office Use: _ sleep study ordered _____ initials

8. Sleep Apnea Syndrome Yes_ No_

If Yes: Year Diagnosed: _____
Last sleep study: _____ month/year
CPAP used: Yes_ No_

9. Heartburn/esophagitis/hiatus hernia? Yes_ No_

If Yes: Year Diagnosed: _____
Upper GI series? Yes_ No_
Endoscopy? Yes_ No_
Medications: _____
Frequency of use:_____

10. Belching up acid or sour fluid. Yes_ No_
11. Coughing or choking at night? Yes_ No_

Office Use: UGI/endoscopy

12. Gallbladder disease? Yes_ No_

If Yes: How was it Diagnosed? _ Ultrasound _ Physical Exam

13. Leakage of urine with laughing/coughing/sneezing? Yes_ No_

If Yes: Wear pads frequently? Yes_ No_

15. Low back strain/Pain/Sciatica? Yes_ No_

If Yes: Seen by Chiropractor? Yes_ No_
Orthopedic Surgeon? Yes_ No_
Seen by Family Doctor? Yes_ No_

Medications taken: _____

16. Pain in Hips/Knees/Ankles/Feet ? Yes_ No_

If Yes: Seen by Chiropractor? Yes_ No_
Orthopedic Surgeon? Yes_ No_
Seen by Family Doctor? Yes_ No_

Medications taken _____

17. Weight related injuries and trauma: _____

_____

18. Venous Stasis Disease ? Yes_ No_

If Yes: Do you have Edema? Yes_ No_
Scaly & Thick Skin? Yes_ No_
Leg Ulcers? Yes_ No_

19. Gout? Yes_ No_

If Yes: Gouty Arthritis? Yes_ No_
Using Medication? _____

20. Bra size (females only): _____

Skin depressions from bra straps? Yes_ No_

Do you have shoulder pain? Yes_ No_

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

_ Measles _ Mumps _ Chickenpox _ Obesity

_ Rheumatic fever _ Heart murmur _ Asthma _ Tonsillectomy

Female Patients:

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: _____

Other Contraceptive method:_____

Serious Illnesses:

Have you had:

_ Hepatitis _ Blood Transfusion _ AIDS/HIV Exposure

_ Colitis _ Kidney Disease _ Bleeding Abnormality

_ Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness Date Treatment

_____

_____

_____

_____

_____

Major Surgery Date

_____

_____

_____

_____

_____

_____

Allergies:

Allergic to any medications?: Yes_ No_ If Yes, please list medication and reaction:

_____

_____

Allergic to: Surgical tape :Yes_ No_ Latex : Yes_ No_ Iodine : Yes_ No_
Other Allergies:

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco: Yes_ No_ Frequency: _____
Are you willing to quit? Yes_ No_
Do you use alcohol: Yes_ No_ Frequency: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

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

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT : stuffy Nose - runny Nose - hay fever - sinus trouble - earache - headache - blurry vision - double vision - haloes 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 - pain with swallowing - hoarseness

2. RESPIRATORY : cough - wheezing - shortness of breath at night - use of two pillows - blood in sputum - out of breath with exertion - wake up at night short of breath - wake up at night coughing or choking - asthma - emphysema - bronchitis

3. CARDIOVASCULAR : palpitations - pounding heart - skipping heartbeat - pains in chest - pains in neck - pains in arms - squeezing of chest - heart attack - heart murmur - abnormal electrocardiogram - irregular heartbeat - high blood pressure - pain in legs - cold feet - blue toes - blue finger - loss of pulses

4. GASTROINTESTINAL : heartburn - nausea - vomiting - belching fluid in throat - burning in throat - food sticking in chest - pains in stomach - burning in stomach - acid stomach - diarrhea - constipation - pain with bowel movement - blood in stools - hemorrhoids - fissures - cramps - gassiness - irritable colon - colitis

5. GENITOURINARY : pain with urination - trouble starting urine - trouble stopping urine - small urine stream - blood in urine - kidney stones - bladder stones - kidney failure - nephritis - urinary tract infections - frequent urination - getting up at night to urinate - leakage of urine with cough or sneeze

* Men: discharge from penis - loss of erection - painful erection
* Women: vaginal discharge - vaginal bleeding - pain with intercourse - irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid - hyperthyroid - goiter - Grave's Disease - thyroid Nodules - xray to thyroid - diabetes - adrenal gland tumor - frequent flushing - frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints - swelling of joints - redness of skin over joints - warm joints - fluid in joints - arthritis - broken bones - sprains - low back pain - hip pain - knee pain - ankle pain - foot pain - flat feet - slipped disk - herniated disk - sciatica

8. NEUROLOGICAL : dizziness - vertigo - falling to the side - falling at night - numbness - tingling - pins and needles feelings - weakness of any muscles - twitching of muscles - weakness of grip - shakiness - tremors - fainting - convulsions - fits - loss of consciousness

PSYCHOLOGICAL : nervousness - anxiety - depression - thoughts of suicide - suicide attempts - hospitalization for emotional problems - psychiatric treatment - psychological counseling

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Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician			
Internist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Therapist			
Other (Specify)			

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Last name, First, Middle			Date of Birth	Sex	Marital Status M D S W
Street Address			Home Phone		Cell Phone
City	State	Zip code	Social Security #		FAX Number
Employer's Name			Email Address		
Employer's Street Address			Work Phone		Drivers License# & State
City	State	Zip code	Occupation		Race/Ethnicity
Emergency Contact:		Relationship	Cell Phone		Religious Preference
Street Address, City, State, ZIP			Home Phone		Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? Lecture Internet Newspaper Reader/Magazine

_ TV _ Other Friend _ Physician _ Name: _____

Date attended Seminar_____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Signature: _____Date: _____

For Office Use Only:
Date of Physical: _____ Date of Surgery: _____ Auth #:_____