



Health and Medical History Questionnaire

Name _____ Today's date _____

Date of Birth _____ Age _____ Sex: ___M ___F ****Current Height** _____ **Weight:** _____

Allergies:

Please list all allergies *including* foods, drugs, medications, tape, latex or history of asthma and hay fever:

Current Medications:

Please list all drugs, over-the-counter medications or herbal remedies that you are currently taking.

Include dose and frequency for each entry (If more space is required please attach a separate page):

Obesity Related Medical History:

Do you have, or have you had, any of the following illnesses or symptoms. Check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> morning headache | <input type="checkbox"/> excess snoring | <input type="checkbox"/> wake up short of breath |
| <input type="checkbox"/> esophageal reflux | <input type="checkbox"/> heartburn | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> chronic skin infections |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart disease | |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> blood clots in legs or lungs | |
| <input type="checkbox"/> depression | <input type="checkbox"/> asthma | <input type="checkbox"/> urine incontinence | |
| <input type="checkbox"/> sciatica | <input type="checkbox"/> hernia | <input type="checkbox"/> irregular menses | |

Please list any other medical conditions and hospitalizations, past and current:



Past Surgical History:

Please list all surgical procedures and/or operations including dates:

Social history:

Please list your occupation: _____

How many children do you have: _____ Ages: _____

Do you smoke tobacco? _____ If yes, number of packs per day: _____ Years of use: _____

Alcohol use: none few drinks per day few drinks per month few drinks per

Family History:

Do any congenital diseases run in your family, such as bleeding, clotting, gastro-intestinal disease, or other?

Please describe your family influences and/or support network as it pertains to your weight and eating habits.



Weight History

At what age did you become obese? _____ What was your highest adult weight? _____

What is your desired weight _____ Have you ever had weight loss surgery? _____

Weight Loss Programs, Diets and/or Medications: *Please check all boxes that apply:*

- Weight watchers jenny Craig Nutri system Diet Center Atkins
- Weight Mngt Cambridge Slimfast Soutbeach Optifast
- Medifast Xenical Meridia Phentermine Phen-fen
- Redux

Please list **any additional** programs, diets, medications and herbal remedies that you have tried:

Please describe your **most recent** program, diet or medication. Be sure to include weight loss and regained and your thoughts about it:

What has been your **most successful** diet or program or medication, and why? _____

What role does emotion play in your eating? _____

Do you tend to snack through the day? _____

Do you have trouble feeling full after eating? _____

Do you tend to eat late at night? _____

Do you think you eat portions that are too large? _____

Do you crave sweets such as milkshakes, smoothies, candy? _____

What role does **physical activity and exercise** play in your life? _____

What questions would you like to have addressed during your consultation?



Healthy Steps

BARIATRIC & METABOLIC CENTER

Date _____

Patient Information (please print):

Name _____

Address _____

Phone _____

Best number to reach you _____

Cell Phone _____

Your emergency contact person _____

Email _____

Date of Birth _____

Social Security # _____

<p>Please list your pharmacy here:</p> <p>Name _____</p> <p>Location _____</p> <p>Phone _____</p>
--

Marital Status _____

Spouse name _____

Occupation _____

Employer _____

Bus. Phone _____

Primary Insurance

Insurance Co. _____

ID# _____

Policy # _____

Group # _____

Primary Care Physician (required)

Name _____

Address _____

Phone _____

Referring Physician

Name _____

Address _____

Phone _____



Welcome to Healthy Steps Bariatric & Metabolic Center

Included for you is our new patient questionnaire that will require some time to complete. Please take the time to thoroughly complete all the information. The following process will need to be completed prior to receiving a consultation appointment. We have organized this for you in a step by step process.

CONSULTATION PROCESS

1. Complete the enclosed questionnaire and return to Healthy Steps Bariatric & Metabolic Center. Enclose a copy of your insurance card, front and back.
2. Attend one of our educational seminars. Seminar dates and times are located on our web site at www.healthystepsinfo.com. The seminars are 60-90 minutes in length.
3. Contact our office for a consultation appointment with either Dr. Woodbury or Dr. Cortez. Please note you must have attended an educational seminar prior to being given a consultation appointment.

QUESTIONNAIRE PROCESS

1. Once we receive your questionnaire it will be reviewed for completeness. We will contact you via email or mail if there is any missing information, which would prevent us from processing your paperwork.
2. We will verify your insurance benefits, and make sure that bariatric surgery is a covered benefit of your plan. We will contact you via email or mail if there are any insurance problems that would prevent you from being a patient at Healthy Steps Bariatric & Metabolic Center.

The above processes can take several weeks. We receive a large volume of requests, and process them as quickly as we can. If you have any questions please contact us. You may reach us via email at contact@healthystepsinfo.com or 707-577-7800.

We look forward to meeting you soon.

Carol Wyckoff
Program Director