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CENTER FOR ADVANCED SURGERY
DALLAS
A member of HealthTexas Provider Network

HEALTH HISTORY QUESTIONNAIRE

Date ____________________

Patient Name ___________________________________ Date of Birth _____________________ Age __________

Daytime phone (_____) __________________________ Other phone (_____) ____________________________

Email ________________________________

How did you hear about us? ☐ My doctor ☐ Yellow pages ☐ News ad ☐ Radio/TV ☐ Friend/family

☐ Web site ☐ Other ____

Reason for today's visit ____

Have you had the following tests:

Screening colonoscopy ☐ Yes If so, when? ___________ ☐ No

Sleep study ☐ Yes If so, when? ___________ ☐ No

Physicians

Referring Physician ____ Phone (_____) ______________________

Primary Care Physician _______________________________________ Phone (_____) ______________________

Surgeon ____ Phone (_____) ______________________

Oncologist ____ Phone (_____) ______________________

GI Physician ____ Phone (_____) ______________________

Psychologist____ Phone (_____)______________________

Psychiatrist____ Phone (_____) ______________________

Cardiologist____ Phone (_____) ______________________

Endocrinologist____ Phone (_____) ______________________

Nephrologist____ Phone (_____) ______________________

Other MD ____ Phone (_____) ______________________

Allergies	Yes	No	**Initials** ________________
Contrast dye / Shellfish / Iodine	☐	☐	

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Adhesives	☐	☐
Dermabond	☐	☐

Allergies (cont.)

Latex	☐	☐

Do you have any allergies to medications? ☐ Yes ☐ No
If **Yes**, please list the drugs and type of reaction:
____

____

Medications - *Please list your current medications and doses below*
Please include over-the-counter medications & supplements, i.e. vitamins, herbals, aspirin, etc.)

Name	Strength	Frequency
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________

I DO NOT TAKE ANY MEDICATIONS – ☐ PLEASE √ BOX

Preferred Pharmacy ____

Medical History – *list any past/current problems and/or illnesses*
Examples: Diabetes, High Cholesterol, Hyperthyroidism or Heart Disease

☐ Obstructive Sleep Apnea	☐ Hypertension	☐ Hyperlipidemia
☐ GERD	☐ Diabetes	☐ Other (please list below)

____

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____
____
____

Surgical History **– I HAVEN'T HAD ANY SURGICAL PROCEDURES ☐ PLEASE √ BOX**

Examples: Appendectomy, Colon Resection, Fundoplication, TIF, Bariatric

Surgery	**Where**	**Date**	**Any complications?**
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Weight Loss History

Height:______________________ Weight:______________________ BMI:______________________

How long have you been at your current weight? ______________________________

At what age did you become obese?______________________ What is your goal weight?______________

What is your lowest adult weight?______________________ What year?______________________

What is your highest adult weight?______________________ What year?______________________

What type of eating style do you have?

☐ Big eater ☐ Sweets ☐ Snacker ☐ Grazer

☐ Combination of all

How many times do you eat out per week?____

Do you exercise? ☐ Yes ☐ No If yes, how often?__________________________________

Medically Supervised Treatment Regiments:

Please list all diets and medications for weight loss you have used and the treating physician

Did you take Fen-Phen? Year:______________ Physician:______________________

Type/Name:______________ Year:______________ Physician:______________________

Type/Name:______________ Year:______________ Physician:______________________

Other Weight Loss Attempts

Program	**Months(s)/Years(s)**	**Length of Participation**	**Amount of Weight Loss**
Weight Watchers			
Exercise			
Calorie Control/Counting Calories			
Slim Fast			
Medifast			
Nutrisystems			
Sugar Busters			

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Jenny Craig			
Metabolife			
Optifast			
Xenical			
Adkins/South Beach			
Dexatrim			
Meridia			
Overeaters Anonymous			
LA Weight Loss			
Hydroxycut			
All			
Other			

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

Procedures & Testing

Please indicate if you have had any of the following procedures.

	Yes	No	Where	Date
CT Scan – Chest/Abdomen/Pelvis	☐	☐	______________________	__________________
Ultrasound – Abdomen	☐	☐	______________________	__________________
PET scan	☐	☐	______________________	__________________
pH & Motility studies	☐	☐	______________________	__________________
Endoscopy	☐	☐	______________________	__________________
Esophagram or Swallow study	☐	☐	______________________	__________________
Labs	☐	☐	______________________	__________________
Other: ________________________________			______________________	__________________

Please indicate if you have any of the following:

	Yes	Date
LVAD	☐	________________________________
Pacemaker	☐	________________________________
Defibrillator	☐	________________________________

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Family Medical History

Relationship	Name	Anesthesia problems	Asthma	Autoimmune disease(s)	Coronary artery disease	Cancer	Crohn's disease	Clotting disorder	COPD	Depression	Diabetes	Heart disease	Hyperlipidemia	Hypertension	Inflammatory bowel disease	Kidney disease	Obesity	Sleep apnea	Stroke	Colon cancer	Gallbladder disease	Ulcerative colitis
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						

Unknown or No known problems ☐

Other family history (Examples: grandmother with breast cancer, aunt with heart disease)

Family Member	Disease
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____
______________________	____

Social History

	Yes	No	
Do you currently smoke cigarettes?	☐	☐	Packs/day ___________
Have you ever smoked?	☐	☐	Year you quit ___________
Do you drink alcohol?	☐	☐	Drinks/week ___________
Have you ever been treated for alcoholism?	☐	☐	
Have you ever used intravenous drugs?	☐	☐	
Are you currently employed?	☐	☐	Occupation _______________
Do you have children?	☐	☐	
Do you exercise frequently?	☐	☐	How often? ______________
	☐		

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What is your marital status?

- ☐ Single
- ☐ Married/Partnered
- ☐ Divorced
- ☐ Widowed

Other comments? ____

____

Would you like to sign up for MyChart today?

Manage your health, your way, using MyChart. It's an online tool designed to help you stay on track to a healthier you by providing secure anytime/anywhere access from your computer, tablet or smartphone.

☐ Decline ☐ Already in Use ☐ Enroll today

Patient Signature ______________________________ Date ________________

Acknowledgement

☐ I am ready to pursue surgery as an option for treatment for my obesity.
☐ I agree to follow the program as prescribed and actively participate in my follow up care.
☐ I understand that I am primarily responsible for obtaining insurance approval for this procedure. I will furnish all records requested by the program in a timely manner. I will make and complete all necessary appointments to fulfill necessary requirements.
☐ I understand I am responsible for any charges not covered by my insurance.

______________________________ ________________
Patient Signature Date

For Office Use Only:

BP ____________ Wt ____________
HR ____________ Ht ____________
Temp ____________ RR ____________
SPO2 ____________

Reviewed by ______________________________ MD Date ________________

Entered to EMR by ______________________________ Date ________________