Community Health Network

COMMUNITY MEDICAL WEIGHT LOSS AND WELLNESS

North
7250 Clearvista Drive, Suite 100
Indianapolis, IN 46256
Phone: 317-621-7771
Fax: 317-621-6040

South
8711 South US 31
Indianapolis, IN 46227
Phone: 317-887-7771
Fax: 317-497-2510

NEW PATIENT HEALTH QUESTIONNAIRE

Date:_____

Who referred you to our office:_____

Last Name:_____First_____M.I.__

Patient Age:_____ Date of Birth: ____/____/_____ SSN**:**_____-_____-_____ Male or Female

Address:_____

City:_____State_____Zip:_____

Phone:_____Cell:_____Work:_____

Email address:_____ **May we contact you at work?** Y or N

Marital Status: □ Single □ Married □ Widow □ Widower □ Separated □ Divorced
Race: □ Caucasian □ African American □ Hispanic □ Other

Spouse/Next of Kin:_____Relationship:_____

Phone:____ _____Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact Name:_____

Relationship:_____Phone:_____

Community Health Network

Patient Name: _____ ***Date of Birth:***_____

Referring Physician:_____Phone:_____

Address: _____City_____State_____ZIP_____

Primary Care Physician:_____Phone:_____

Address:_____City_____State_____Zip_____

Employer:_____Address:_____

City:_____State:_____Zip:_____Phone:_____

Please list all providers involved in your care:

Name:_____Specialty:_____

Address:_____Phone:_____

City:_____State:_____Zip:_____

Name:_____Specialty:_____

Address:_____Phone:_____

City:_____State:_____Zip:_____

Name:_____Specialty:_____

Address:_____Phone:_____

City:_____State:_____Zip:_____

Name:_____Specialty:_____

Address:_____Phone:_____

City:_____State:_____Zip:_____

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MEDICAL HISTORY

Name:_____**Height:**_____**Weight:**_____

ALLERGIES OR ADVERSE REACTIONS:

Please state type, including all medication, tape, latex, food, other

Allergy Type:	**Effects/Reactions:**

PAST SURGERIES AND HOSPITALIZATIONS:

Surgery:	**Date:**

CURRENT MEDICATIONS/TREATMENTS:

Including over the counter medication (i.e. vitamins, herbal supplements, diet, sleeping, sinus, headaches and other) O2, CPAP, ETC

Name:	**Dosage:**	**Date Started:**

Community Health Network

Patient Name: _____ ***Date of Birth:***_____

REVIEW OF SYSTEMS

General	Eyes	Ears/Nose/Throat
◻ Fever	◻ Blurring	◻ Earache
◻ Chills	◻ Double vision	◻ Ear discharge
◻ Sweats	◻ Irritation	◻ Ringing in ears
◻ Anorexia	◻ Discharge	◻ Hearing loss
◻ Fatigue	◻ Vision loss	◻ Nasal Congestion
◻ Lack of energy/feeling faint	◻ Eye pain	◻ Nosebleeds
◻ Weight loss	◻ Sensitivity to light	◻ Sore throat/Hoarseness
◻ **No Issues**	◻ **No Issues**	◻ **No issues**
Cardiovascular	**Respiratory**	**Gastrointestinal**
◻ Chest pains	◻ Cough	◻ Nausea/ ◻ Vomiting
◻ Palpitations	◻ Shortness of breath	◻ Diarrhea/ ◻ Constipation
◻ Fainting	◻ Excessive sputum	◻ Change in bowel habits
◻ Shortness of breath	◻ Spitting up blood	◻ Abdominal pain
◻ Difficulty breathing	◻ Wheezing	◻ Dark stools
◻ Swelling in extremities	◻ Snoring while asleep	◻ Bloody stool (bright red)
◻ Poor circulation	◻ **No issues**	◻ Jaundice
◻ **No issues**		◻ Heartburn
	Musculoskeletal	◻ **No issues**
Genitourinary	◻ Back pain	
◻ Vaginal discharge	◻ Joint pain	**Skin**
◻ Incontinence	◻ Joint swelling	◻ Rash
◻ Pain upon urination	◻ Muscle cramps	◻ Itching
◻ Blood in urine	◻ Muscle weakness	◻ Dryness
◻ Frequent urination	◻ Stiffness	◻ Suspicious lesions
◻ Absence of menstruation	◻ Arthritis	◻ Non-healing wounds
◻ Normal menstruation	◻ Difficulty moving around	◻ Hirsutism (abn facial hair)
◻ Abnormal vaginal bleeding	◻ **No issues**	◻ **No issues**
Neurologic	**Psychiatric**	**Endocrine**
◻ Pelvic pain	◻ Depression	◻ Cold intolerance
◻ Transient paralysis	◻ Anxiety	◻ Heat intolerance
◻ Weakness	◻ Memory loss	◻ Fatigue
◻ Numbness or tingling	◻ Mental disturbance	◻ Frequent urination
◻ Seizures	◻ Suicidal thoughts	◻ Weight change
◻ Fainting	◻ Hallucinations	◻ Increased appetite
◻ Tremors	◻ Anger/irritability	◻ Excess thirst
◻ Vertigo	◻ Paranoia	◻ Cravings
◻ Headaches/Migraines	◻ **No issues**	◻ Sleepy during waking hours
◻ **No issues**		◻ Insomnia
	Allergic/Immunologic	◻ **No issues**
Heme/Lymphatic	◻ Hives	
◻ Abnormal bruising	◻ Hay fever	
◻ Bleeding	◻ Persistent infections	
◻ Enlarged lymph nodes	◻ HIV exposure	
◻ Deep vein thrombosis	◻ No issues	
◻ **No issues**		

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Patient Name: _____ ***Date of Birth:***_____

Do you smoke?	Yes No	Amount per day: _____
Do you use smokeless tobacco products?	Yes No	Amount per day: _____
Do you drink alcohol?	Yes No	Amount per day: _____
Do you drink caffeinated drinks?	Yes No	Amount per day: _____
Do you use recreational drugs?	Yes No	

FAMILY HISTORY

	FATHER	MOTHER	BROTHER	SISTER	PATERNAL FATHER	PATERNAL MOTHER	MATERNAL FATHER	MATERNAL MOTHER
BLEEDING PROBLEMS								
CANCER: TYPE								
DIABETES								
HEART DISEASE								
HIGH BLOOD PRESSURE								
STROKE								
OBESITY								

Pharmacy Name:_____
Location_____
Phone:_____ **Zip Code (if known):**_____

Communication Disclosure:

I, the undersigned, hereby authorized Community Bariatric Surgeons to **discuss my medical condition and financial matters pertaining to my care with:**

(name)_____(relationship)_____
(name)_____(relationship)_____
(name)_____(relationship)_____
(name)_____(relationship)_____
(name)_____(relationship)_____

Patient's Signature: _____**Date:** _____

Community Health Network

Community Bariatric Surgeons Today's Date: _____
Sleep Disorder Screening Questionnaire Surgeon: _____

Last Name (Printed): _____First Name (Printed): _____

DOB: _____ Age:_____ Sex: _____Height: _____Weight: _____

Home Address: _____
City/State_____ Zip_____

Home Phone: _____ Alternate Phone: _____

Please fill out completely:

1. Have you ever been diagnosed with a sleep disorder? Yes No
2. Are you currently on a CPAP/BIPAP machine? Yes No
3. Do you snore? Yes No
4. Do others say you stop breathing while you are sleeping? Yes No
5. Do you have trouble staying awake when you need or want to be awake? Yes No
6. Do you fall asleep during any of the following?

Watching TV?	Never	Rarely	Sometimes	Frequently
While at work?	Never	Rarely	Sometimes	Frequently
At Movies, Church?	Never	Rarely	Sometimes	Frequently

7. Have you ever fallen asleep while driving? Yes No
8. Do you fall asleep frequently while reading books or newspapers? Yes No
9. Do you have trouble getting to sleep or staying asleep? Yes No
10. Do you still feel tired after eight hours of sleep? Yes No
11. Do you frequently get less than seven hours of sleep in a day? Yes No
12. Do you ever have restless legs during sitting/lying? Yes No
13. Have you ever noticed jerking leg movement during sleep hours? Yes No
14. How much of the following caffeine sources do you consume each day:
    Coffee_____ **Soft Drinks**_____ **Tea**_____
    Other_____
15. Do you believe you have any other sleep related problems? Yes No
    Please describe_____

For Office Use Only

Indicates a sleep study is recommended prior to surgery: Y N
Date faxed to scheduling: _____ Staff Member: _____

Fax Report to 317-621-6040 **Mail Report to: 7250 Clearvista Dr. #210 Indianapolis, IN 46256**

Community Health Network

Patient Name _____
DOB_____

Medical History Questionnaire

Have you ever been diagnosed with the following?			Y	N
Diabetes Mellitus (circle one)	Type I	Type 2		
Gestational Diabetes (during pregnancy)				
Hypertension				
Hypothyroidism (underactive)				
Hyperthyroidism (overactive)				
Liver disease				
Hepatitis				
Gallstones				
Heart Disease (atherosclerosis)				
Heart Arrhythmia (irregular heartbeat)				
Sleep apnea				
Asthma				
Other breathing problems (If so, what_____)				
Cancer	(if so, what_____)			
Osteoarthritis				
Other arthritis				
Gout				
Polycystic ovarian syndrome				
Abnormal menses				
Menopause				
Hypogonadism (males)				
Breast enlargement (males)				
Low testosterone level (male) or elevated testosterone level (female)				
Depression				
Anxiety				
Eating disorder	(if so, which_____)			

		Y	N
Binge eating disorder			
Headaches/migraines			
Glaucoma			
Hair loss/alopecia			
Psychiatric disorder such as psychosis			
High cholesterol			
Stroke			
Blood clot in leg or lungs	(if so, which_____)		
Blood disorder such as anemia, hemophilia	(if so, which_____)		
HIV			
Autoimmune disease	(if so, which_____)		
Kidney disease			
Kidney stones			
Seizures			

Do you consume an abnormally large amount of food in a short period of time?
(compared to what others might eat in that same circumstance) AND
Do you feel a loss of control over eating during that episode?

Do you consume food faster than normal?

Do you consume food until uncomfortably full?
Do you consume large amounts of food when not hungry?
Do you consume food alone because you are embarrassed over how much you are eating?
Do you feel disgusted, depressed or guilty after the binge?
Do you feel distressed about the binge eating?
Does the binge eating occur on average at least once per week for three months?
Do you purge (make yourself throw up) after you binge?

Have you been the victim of abuse (sexual, psychological/verbal, trauma) Y N

At what stage of wanting to lose weight would you say you are? (circle one)
Considering it Ready to start Already actively trying
Why are you trying to lose weight? _____
Have you tried a weight loss program in the past?
When?_____
What happened (circle one) Gradual loss Rapid loss No weight loss
How did you feel about it?
Why did you discontinue the weight loss program you were on?
Did you use weight loss medications?
Which?
How long?
Why did you discontinue?
What has worked best for weight loss for you?
Do you exercise?
If so, what have you tried?
How often do you exercise?
What do you like best?
What is your goal weight?
Females: Are you trying to get pregnant or hoping to get pregnant soon?

Dietary History

What do you typically eat for breakfast?_____
For lunch?_____
For dinner?_____
Snacks?_____
How many meals do you eat per day?_____
How much do you eat at each meal and snack? (typical portion size)_____
What are your typical beverages during the day and how much?_____
Do you skip meals?_____
Where do you eat mostly?_____
Who cooks mostly?_____
Who shops and where?_____
What foods do you like most?_____
Least?_____
Do you plan meals and snacks ahead?_____
Have you ever kept a food diary?_____
If yes, did it help keep your weight loss goals on track?_____