Community Health Network

Community Bariatric and Medical Weight Loss Services-**NORTH**
7250 Clearvista Dr, Suite 100
Indianapolis, IN 46256 (317) 621-7771

Community Bariatric and Medical Weight Loss Services-**SOUTH**
8711 US 31 South
Indianapolis, IN 46227 (317)-887-7771

☐ **North Surgical Program** ☐ **North Medical Weight Loss Program**

☐ **South Surgical Program** ☐ **South Medical Weight Loss Program**

Date of Birth: _____ **Sex:** ☐ M ☐ F

First Name: _____ **Middle Initial:** ____ **Last:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline

Address: _____ **City/State:** _____ **Zip:** _____

Phone: Home: (___) _____ Cell: (___) _____ Email: _____

Employer: _____ **Work Phone:** (___) _____ ext. _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** (___) _____

Primary Insurance Information:

Insurance Name: _____ **Customer Service Phone:** (___) _____

Policy ID #: _____ **Group #:** _____ **Plan #:** _____

Name of Insured: _____ **Relationship:** _____

Insured's Social Security Number: _____ **Insured's Date of Birth:** _____

Insured's Employer: _____

Secondary Insurance Information:

Insurance Name: _____ **Customer Service Phone:** (___) _____

Policy ID #: _____ **Group #:** _____ **Plan #:** _____

Name of Insured: _____ **Relationship:** _____

Insured's Social Security Number: _____ **Insured's Date of Birth:** _____

Insured's Employer: _____

Patient Name: _____ DOB: _____

HEALTH HISTORY QUESTIONNAIRE

Please complete in full before your appointment

Thank you for taking time to complete this questionnaire. Your physician will use this information to determine the best treatment plan to meet your needs. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Legal Name (Last, First, M.I.):		
Gender: □ M □ F	Birth Date:	Height:
Which program interests you? □ Medical (non-surgical) □ Surgical □ Undecided		
If you are interested in surgical weight loss, which procedure interests you? **□ Roux en Y Gastric Bypass □ Sleeve Gastrectomy □ DS/SADI** **□ Possible Revision □ Undecided**		
Have you been seen in our office before? □ Yes □ No If yes, how long ago?		
Who referred you to our office?		

PRIMARY HEALTH CARE PROVIDER (Physician, Nurse Practitioner, etc.)	
Name:	Phone:
Street Address:	

OTHER TREATING PHYSICIANS (i.e. cardiology, endocrinology, psychiatry, gastroenterology, etc.)

Name	Phone Number	Specialty

ALLERGIES Latex Allergy? □ YES □ NO

Drug/Environment/Food	Reaction

MEDICATIONS (Please list your prescribed drugs and over-the-counter drugs, such as vitamins, aspirin, allergy meds, etc.)

Name	Drug Strength	Frequency	Reason

Pharmacy Name and Address:

Patient Name: _____ DOB: _____

MEDICAL HISTORY (Have you had any of the following?)			
□ Anemia	□ Clotting Disorder	□ Fatty Liver	□ Shortness of Breath
□ Anesthesia Complications	□ Infectious Disease	□ GERD	□ Sleep Apnea
□ Anxiety	□ Depression	□ Heart Disease	□ Stroke
□ Arthritis	□ Diabetes Mellitus II	□ Heart Murmur	□ Ulcers
□ Asthma	□ Emphysema	□ Hepatitis	□ Substance Abuse
□ Back Pain	□ Epilepsy	□ High Cholesterol	□ Thyroid Disease
□ COPD	□ Gallstones	□ High Blood Pressure	□ Urinary Incontinence
□ Cancer	□ Joint Pain	□ Heart Attack	□ Blood Clots
□ CHF	□ Leg Swelling	□ Seizures	□ Tuberculosis
□ Fibromyalgia	□ Kidney Disease	□ Nerve/Muscle Disease	□ Other
□ PCOS	□ Gout	□ Infertility	□ Other

SURGICAL HISTORY		
□ Appendectomy	□ Cosmetic surgery	□ Joint replacement
□ Brain surgery	□ C-Section	□ Prostate surgery
□ Breast surgery	□ Eye surgery	□ Small intestine surgery
□ CABG	□ Fracture surgery	□ Spine surgery
□ Cholecystectomy (Gallbladder)	□ Hernia surgery	□ Tubal ligation
□ Colon surgery	□ Hysterectomy	□ Valve replacement
□ Tonsillectomy	□ Adenoidectomy	□ Other
□ Vasectomy	□ RNYGB / Sleeve / Band / Other	□ Other

FAMILY HISTORY (Check all that apply)

Family Member	Living / Deceased	Obesity	High Blood Pressure	High Cholesterol	Diabetes	Stroke	Cancer	Other
Mother								
Father								
Sibling □ M □ F								
Sibling □ M □ F								
Sibling □ M □ F								
Other:								
Other:								

SOCIAL HISTORY					
Substance	Current Use	Past Use	Amount / Type / How Often	# Years Used	Date Stopped
Alcohol	□Yes □No	□Yes □No			
Drugs	□Yes □No	□Yes □No			
Tobacco	□Yes □No	□Yes □No			
Smokeless Tobacco	□Yes □No	□Yes □No			

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS		Do you **CURRENTLY** suffer from any of the following?	
General	**Eyes**	**Genitourinary**	**Neurological**
□ Fever	□ Eye Pain	□ Painful Urination	□ Dizziness
□ Chills	□ Eye Redness	□ Involuntary Urination	□ Headaches
□ Sweating	□ Sensitivity to Bright Light	□ Frequent Urination	□ Light-headedness
□ Unexpected Weight Loss	□ Visual Disturbance	□ Pelvic Pain	□ Numbness
□ Fatigue	**Respiratory**	□ Blood in Urine	□ Seizures
Head Ears Nose Throat	□ Apnea (Stop Breathing)	□ Penile Pain/Swelling	□ Speech Difficulty
□ Facial Swelling	□ Wheezing	□ Scrotal Swelling	□ Syncope (Fainting)
□ Neck Pain	□ Choking	□ Testicular Pain	□ Tremors
□ Neck Stiffness	□ Cough	□ Urgency	□ Weakness
□ Hearing Loss	□ Shortness of Breath	**Musculoskeletal**	**Psychiatric**
□ Ear pain	**Gastrointestinal**	□ Joint Pain	□ Agitation
□ Tinnitus (Ringing)	□ Abdominal Distension	□ Back pain	□ Depression
□ Nosebleeds	□ Abdominal Pain	□ Gait problem	□ Confusion
□ Congestion	□ Nausea	□ Joint swelling	□ Decreased Concentration
□ Postnasal drip	□ Vomiting	□ Muscle Pain	□ Anxiety
Cardiovascular	□ Diarrhea	**Vascular**	□ Hallucinations
□ Chest pain	□ Constipation	□ Varicose Veins	**Endocrine**
□ Leg swelling	□ Change in Bowel Habits	□ Leg Redness	□ Cold Intolerance
□ Palpitations	□ Difficulty Swallowing	**Women**	□ Heat Intolerance
Hematologic	□ Dark / Bloody Stools	□ Absence of periods	□ Excessive Thirst
□ Enlarged Lymph Nodes	□ Reflux / Heartburn	□ Hot flashes	□ Increased Appetite
□ Bruises/Bleeds Easily	□ Jaundice	□ Facial Hair	□ Unusual Weight Change
□ Abnormal Bleeding			

GYNECOLOGIC HISTORY (Women Only)	
Age periods started?	
Age periods ended?	
Periods are: □ Regular □ Irregular □ Heavy □ Normal □ Light	
Number of pregnancies:	
Number of children:	
Age of first pregnancy:	
Age of last pregnancy:	
Are you trying to get pregnant or hoping to get pregnant soon?	□Yes □No

Patient Name: _____ DOB: _____

WEIGHT HISTORY	
How does your weight affect your life and health? Please be specific:	
When did you become overweight?	□ Childhood □ Teens □ Adulthood □ Pregnancy □Menopause
Did you ever gain more than 20 pounds in less than 3 months?	□Yes □No If so, how long ago?
Lowest adult weight?	
Highest adult weight?	
Period of greatest weight gain? Cause?	
Triggers for your weight gain (check all that apply):	□ Stress □ Marriage □ Divorce □ Illness □ Medication abuse □ Travel □ Injury □ Nightshift work □ Insomnia □ Quitting (circle all that apply): Smoking / Alcohol / Drugs

PREVIOUS WEIGHT LOSS ATTEMPTS (Check all that apply)		
□ Weight Watchers	□ LA Weight Loss	□ Zone Diet
□ South Beach	□ Atkins	□ Medifast
□ HCG Diet	□ Diet Dash	□ Phentermine(Adipex)
□ Nutrisystem	□ Paleo Diet	□ Meridia
□ Jenny Craig	□ Mediterranean Diet	□ Xenecal/Alli
□ Phen/Fen	□ Phendimetrazine(Bontril)	□ Saxenda
□ Topamax	□ Diethylpropion	□ Bupropion(Wellbutrin)
□ Belviq	□ Qsymia	□ Contrave
□ Other	□ Other	□ Other

What was your maximum weight loss? _____

What is your goal weight? _____

What are your greatest challenges with dieting? _____

_____

What worked? _____

What didn't work? _____

Why or why not? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Patient Name: _____ DOB: _____

NUTRITIONAL HISTORY	
How often do you eat breakfast?	_____ days per week at _____ a.m.
Number of times you eat per day:	
Do you skip meals?	□Yes □No
Do you drink caffeinated drinks?	□Yes □No Amount per day:
What are your typical beverages during the day and how much?	
Where do you eat primarily?	
Who cooks at home?	
Who shops and where?	
Have you ever kept a food journal/diary?	

TRIGGERS/CRAVINGS	
Food Triggers (check all that apply): □ Stress □ Boredom □ Anger □ Parties □ Eating Out □ Fast Food □ Seeking Reward □ Other:	
Food cravings: □ Sugar □ Chocolate □ Starches □ Salty □ High Fat □ Large Portions □ Other:	
Favorite foods:	

EATING HABITS	
Have you ever been diagnosed with an eating disorder?	□Yes □No If yes, which one?
Do you get up at night to eat?	□Yes □No If so, how often? _____ times
Do you consume an abnormally large amount of food in a short period of time?	□Yes □No
Do you feel a loss of control over eating?	□Yes □No
Do you consume food until uncomfortably full?	□Yes □No
Do you consume food alone because you are embarrassed over how much you're eating?	□Yes □No
Do you feel disgusted, depressed, or guilty after the binge?	□Yes □No
Does binge eating occur on average at least once per week for 3 months?	□Yes □No
Do you make yourself throw up after binging?	□Yes □No
Have you been the victim of abuse (sexual, psychological, verbal, trauma)?	□Yes □No

EXERCISE	
How often do you exercise?	□ Never □ Occasionally □ 1-3 times a week □ 4-7 times a week □ Other:
What type of exercise?	□ Aerobic □ Strength training □ Walking □ Yoga □ Other:
How long do you exercise?	
Do you have a gym membership?	□Yes □No

Patient Name: _____ DOB: _____

WHY I WANT TO LOSE WEIGHT	
Before you begin your weight loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others. Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!	
1.	
2.	
3.	
4.	
5.	
Describe the physical benefits you hope to get by losing weight:	
Describe the functional benefits you hope to get by losing weight:	
Describe the medical benefits you hope to get by losing weight:	
Describe the psychological benefits you hope to get by losing weight:	

Please answer yes or no to the following questions:

Within the past 12 months, have we worried about our food running out before we had money to buy more.	**Yes ( ) No ( )**
Within the past 12 months, the food we bought just didn't last and we didn't have enough money to get more.	**Yes ( ) No ( )**

Patient Name: _____ DOB: _____

SLEEP QUESTIONNAIRE		
	Do you currently use a CPAP or BIPAP?	□Yes □No
Snoring	Do you snore loudly (louder than talking or to be heard through a closed door)?	□Yes □No
Tired	Do you often feel tired, fatigued, or sleepy during the day?	□Yes □No
Observed	Has anyone observed you stop breathing during your sleep?	□Yes □No
Blood Pressure	Do you have or are you being treated for high blood pressure?	□Yes □No

Use the scale to the right to rate the following situations on your chances of dozing off, not just feeling tired. If you have not done any of these recently, try to determine how they would have affected you.	**No chance of dozing 0** **Slight chance of dozing 1** **Moderate chance of dozing 2** **High chance of dozing 3**
EPWORTH SLEEPINESS SCALE	SCORE
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (theater or in a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after lunch without alcohol	
In a car, stopped for a few minutes in traffic	

Patient Name: _____ DOB: _____

GERD-Health Related Quality of Life Questionnaire (GERD-HRQL)

Do you take a Proton Pump Inhibitor (PPI)? □ Yes □ No

If no, how long have you been off the PPI? _____ days / months

Scale:

0 = No Symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activity
5 = Symptoms are incapacitating to do daily activities

*Please check the box to the right of each question which best describes your experience over the past **2 weeks***

1. How bad is the heartburn?	□0 □1 □2 □3 □4 □5
2. Heartburn when lying down?	□0 □1 □2 □3 □4 □5
3. Heartburn when standing up?	□0 □1 □2 □3 □4 □5
4. Heartburn after meals?	□0 □1 □2 □3 □4 □5
5. Does heartburn change your diet?	□0 □1 □2 □3 □4 □5
6. Does heartburn wake you up from sleep?	□0 □1 □2 □3 □4 □5
7. Do you have difficulty swallowing?	□0 □1 □2 □3 □4 □5
8. Do you have pain with swallowing?	□0 □1 □2 □3 □4 □5
9. If you take medication, does this affect your daily life?	□0 □1 □2 □3 □4 □5
10. How bad is the regurgitation?	□0 □1 □2 □3 □4 □5
11. Regurgitation when lying down?	□0 □1 □2 □3 □4 □5
12. Regurgitation when standing up?	□0 □1 □2 □3 □4 □5
13. Regurgitation after meals?	□0 □1 □2 □3 □4 □5
14. Does regurgitation change your diet?	□0 □1 □2 □3 □4 □5
15. Does regurgitation wake you from sleep?	□0 □1 □2 □3 □4 □5

16. How satisfied are you with your present condition?
□ Satisfied □ Neutral □ Dissatisfied

Date completed: _____