Doctors Community Surgical Associates
240-965-4405

PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fill out this important information fully and completely.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
PCP or referring doctor:	**Date of last physical exam:**
Education: ☐High School ☐College ☐Masters ☐Doctorate	**Occupation:**

WEIGHT HISTORY

Current Weight:		**Current Height:**
At what age did you begin to have trouble managing your weight?	☐ Birth-12	☐ >Age 40
	☐ 13-19	
	☐ 20-40	

Have you discussed your weight problem with your doctor in the past two years? ☐ **Yes** ☐ **No**

In the last two years, how long has your doctor worked with you to lose weight?

Did your doctor recommend bariatric surgery? ☐ Yes ☐ No

Eating Behavior

☐ Large Portion	☐ Don't chew well	☐ Enjoy sweets
☐ Frequent snacks	☐ Always hungry	☐ Enjoy soda
☐ Eat Fast	☐ Never hungry	☐ Skip meals
☐ Fast Food > 2 times / week	☐ Eat secretly	☐ Eat chips/pretzels

I Overeat when I feel:

☐ Depressed ☐ Lonely ☐ Bored ☐ Nervous ☐ Happy

Weight loss programs in which you have participated:

Commercial weight loss program: (Weight Watchers, Medifast, Jennie Craig, etc.) ☐ YES ☐ NO

Self-Directed (Diet/Exercise) ☐ YES ☐ NO

Medically Supervised Programs (Medications, injections, or consult with Nutritionist, .etc.) ☐ YES ☐ NO
Name of Provider: _____

Where do you carry most of your weight?

Using a scale from 0-10 (10 being the most severe), how severe do you think your weight problem is?

0 1 2 3 4 5 6 7 8 9 10 (circle one)

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

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Associated Symptoms

Have you ever had:

- ❑Chest pain
- ❑Racing heart/skipped beats
- ❑Blood clots in legs
- ❑Do you snore
- ❑Restless sleep/difficulty sleeping
- ❑Abnormal pain
- ❑Frequent boils or skin infections
- ❑Diarrhea
- ❑ Heartburn/reflux
- ❑Shortness of breath
- ❑Swelling in legs
- ❑Wake up gasping for breath
- ❑Back pain
- ❑Urinary incontinence with coughing/sneezing
- ❑Problems conceiving/infertility
- ❑Joint pain ___hips _____knees _____ankles _____feet

Medical History

List all health conditions for which you are **currently** receiving care, e.g. diabetes, sleep apnea, high blood pressure, etc. Describe illnesses even of it did not require hospitalization.

_____

_____

_____

- ❑Heart attack
- ❑Asthma
- ❑High blood pressure
- ❑Elevated cholesterol
- ❑Diabetes
- ❑Thyroid problems
- ❑Pneumonia
- ❑Blood clots in lungs
- ❑Kidney problems
- ❑Problems with gallbladder

Is there any reason you cannot receive a blood transfusion? ❑No ❑Yes_____

Surgical History

Year	Reason	Hospital
	Weight Loss surgery	
	Surgery for reflux/heartburn	
	Gallbladder removed (Laparoscopic or open)	
	C-Section	
	Hernia repaired	
	Hysterectomy	
	Surgery for adhesions	
	Surgery to remove small intestines	
	Surgery on colon	
	Other	

Other hospitalizations: List all hospitalizations in the last 5 years include the reason and date

Year	Reason	Hospital

Please turn to next page

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

SOCIAL HISTORY

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Father	Mother	Siblings	Children	Grandparents
Obesity					
Diabetes					
Cardiovascular Disease					
Heart Attack					
Blood Clots to Legs or Lungs					
High Blood Pressure					
Sleep Apnea					
Early Death & cause					
Anesthesia Problems					
Cancer					

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REVIEW OF SYSTEMS

Neurologic

Have you ever fainted?	❑Yes ❑No	Had a convulsion?	❑Yes ❑No
Do you have any of the following:			
Double Vision?	❑Yes ❑No	Weakness in arms or legs	❑Yes ❑No
Severe headaches	❑Yes ❑No	Pain on one side of head	❑Yes ❑No

Cardiac

Chest pain or tightness	❑Yes ❑No	With exertion	❑Yes ❑No	At rest	❑Yes ❑No
Stress Test	❑Yes ❑No	Date of last stress test_____			
Palpitations		❑Yes ❑No	Heart attack		❑Yes ❑No
Edema(ankle swelling)		❑Yes ❑No	Abnormal EKG		❑Yes ❑No
Open heart surgery		❑Yes ❑No	Scaly, thick skin in legs		❑Yes ❑No
Heart catheterization		❑Yes ❑No	Leg ulcers		❑Yes ❑No

Pulmonary

Do you have:			
Trouble sleeping	❑Yes ❑No	Asthma	❑Yes ❑No
Morning headaches	❑Yes ❑No	Snoring	❑Yes ❑No
Daytime drowsiness	❑Yes ❑No	Awaken at night	❑Yes ❑No
Restless sleep	❑Yes ❑No	Cough up blood	❑Yes ❑No

Psychiatric

Do you have a history of:			
Psychiatric illness	❑Yes ❑No	Depression:	❑Yes ❑No
Suicide attempts	❑Yes ❑No	Obsessive compulsive disorder	❑Yes ❑No
Bipolar or manic depression	❑Yes ❑No	Anxiety/panic attacks	❑Yes ❑No

Gastrointestinal

Do you have reflux or GERD?	❑Yes ❑No		
Have you had stomach pain which:			
Occurs 1-2 hours after meals	❑Yes ❑No		
Is precipitated by fried/ greasy foods	❑Yes ❑No		
Awakens you at night	❑Yes ❑No		
Occurs while eating /immediately after	❑Yes ❑No		
Do you have:			
Abdominal cramps	❑Yes ❑No	Mucous in stools	❑Yes ❑No
Alternating diarrhea and constipation	❑Yes ❑No	Black stools	❑Yes ❑No
Pain during or after bowel movement	❑Yes ❑No		

Musculoskeletal

Have you had:			
Pain in calves while walking	❑Yes ❑No	Joint pain or arthritis	❑Yes ❑No
Pain in hips,knees,ankles,feet	❑Yes ❑No	Cramps in legs at night	❑Yes ❑No
Do you have back Problems	❑Yes ❑No	Do you have difficulty walking	❑Yes ❑No

Genitourinary

Have you had:			
Burning with urination	❑Yes ❑No	Dark colored urine	❑Yes ❑No
Loss of bladder control while laughing or coughing	❑Yes ❑No	Trouble starting urination	❑Yes ❑No
		Blood in urine	❑Yes ❑No
Have you ever passed a kidney stone	❑Yes ❑No		
Urinary frequency/awakening at night	❑Yes ❑No		