Name _____ DOB _____

# Midsouth Bariatrics/George Woodman, MD

**6029 Walnut Grove Road, Suite 100**
**Memphis, TN 38120**
**901-869-2000**
**901-869-2009 fax**
**www.clubnewyou.com**

## HEALTH QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number _____

Home Phone: (____) _____ Mobile Phone:(____) _____

E-Mail: _____

Occupation: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____

Date of Birth: _____

Driver's license #: _____

Health Insurance: _____

ID #: _____ Policy #: _____ Group # _____

Referring Physician: _____

Principal Insurance Holder: ☐ Self ☐ Spouse ☐ Partner

☐ Other _____

**Emergency Contact**

Name: _____

Address: _____

_____

Phone: (____) _____

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Friend

☐ Other _____

Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

**Primary Care Physician**

Name: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

**WEIGHT LOSS HISTORY**

Please check the appropriate boxes and add notes as needed (please be specific).
My obesity started: ☐ In childhood ☐ At puberty ☐ As an adult
☐ After pregnancy ☐ After a traumatic event
☐ _____

Additional notes regarding the onset of obesity: _____
_____
_____
_____
_____

**Weight Loss Programs/Diets/Medications**
(please list type and dates)
☐Medically supervised weight loss attempts: _____
_____
_____
_____
_____
_____

☐Weight loss programs: _____
_____
_____
_____

☐Diets: _____
_____
_____

Height: _____
Highest adult weight: _____ Date: _____
Lowest adult weight: _____ Date: _____
Most weight lost on any program: _____ Program Type: _____

**Taste preferences** (please check all that apply)
☐ Sweets ☐ Salty ☐ Fast food ☐ Comfort foods ☐ _____

**Eating Habits** (please check all that apply)
☐ Binge eater ☐ Stress ☐ Boredom ☐ loneliness ☐ _____

Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

Please list any medications to which you are **allergic:**

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Please list any **medications, vitamins and/or herbal supplements** you are presently taking:

| Medication | Dosage | Time taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
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Please list all **previous surgeries and hospitalizations:**

| Procedure/Diagnosis: | Date | Hospital |
|---|---|---|
| | | |
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Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

## Family History

Please check which, if any, of your family members had any of the following conditions:

| Condition | Sibling | Mother | Father | Grand-parent | Aunt/ Uncle | Comment |
|---|---|---|---|---|---|---|
| Anemia | | | | | | |
| Bleeding Problems | | | | | | |
| Blood Clots | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Gallstones | | | | | | |
| Gout | | | | | | |
| Heart Disease | | | | | | |
| High Blood Pressure | | | | | | |
| Kidney Disease | | | | | | |
| Obesity | | | | | | |
| Sleep Apnea | | | | | | |
| Stroke | | | | | | |

## Obesity related conditions

(please check if you have any of the following conditions)

- ☐ Belching of sour fluid
- ☐ Coughing or choking at night
- ☐ Daytime falling asleep
- ☐ Diabetes Mellitus
- ☐ Gout
- ☐ Heartburn/esophagitis
- ☐ High Cholesterol
- ☐ Joint pain/Arthritis
- ☐ Shortness of breath
- ☐ Sleep Apnea Syndrome
- ☐ Bulimia/Excessive vomiting
- ☐ Daily Headaches
- ☐ Depression
- ☐ Gallbladder disease
- ☐ Hernia
- ☐ Hiatus Hernia
- ☐ High Blood Pressure
- ☐ Leakage of Urine
- ☐ Rash/Dermatitis
- ☐ Swollen Ankles/Feet

## Habits

| | | | |
|---|---|---|---|
| Are you a smoker? | ☐No | ☐Yes | Packs/day: _____ |
| Have you ever been a smoker? | ☐No | ☐Yes | Age started: _____ Age quit: _____ |
| Do you consume alcohol? | ☐No | ☐Yes | Drinks/day: _____ |
| Do you use recreational drugs? | ☐No | ☐Yes | Type/frequency: _____ |

Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

Please check yes or no if you had any of the following **medical conditions** *at any time:*

| Condition | No | Yes | Comment |
|---|---|---|---|
| Allergies | | | |
| Anemia | | | |
| Asthma | | | |
| Bladder/Kidney infections | | | |
| Blood transfusions | | | |
| Cancer | | | |
| Colitis or Irritable Bowel Syndrome | | | |
| Easy bruising | | | |
| Epilepsy/Seizures | | | |
| Excessive/heavy bleeding | | | |
| Fainting | | | |
| Frequent nausea | | | |
| Heart attack | | | |
| Heart failure | | | |
| Heart murmur | | | |
| Heart palpitations | | | |
| Heavy drinking | | | |
| Hemorrhoids | | | |
| Hepatitis | | | |
| Kidney Stones | | | |
| Leg-cramping | | | |
| Liver disease | | | |
| Lung disease/Pneumonia | | | |
| Migraine/severe headaches | | | |
| Rheumatic fever | | | |
| Stroke | | | |
| Thyroid trouble | | | |
| Tuberculosis | | | |
| Tumors | | | |
| Ulcers | | | |
| Varicose veins | | | |

**Women only**

Date of last menstrual period: _____

Are your menstrual periods regular? _____

Are you using birth control? _____ If yes, what type: _____

Number of Pregnancies: _____ Number of live births: _____

Other comments: _____

_____

_____

_____

Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

## Exercise

Please describe your exercise routine. Include type of exercise, frequency and physical limitations.

## Other Concerns

Please write any other concerns that you have regarding your health or bariatric surgery.

**DO YOU HAVE A HISTORY OF BLOOD CLOTS (DVT, PE)?**

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# Personal Statement

Patient Name_____

Date_____

Please tell us in your own words why you are asking to have weight loss surgery. Include in your statement the effect of weight on your health, employment, social life, finances, etc. Please use additional paper if necessary. This information is privileged and confidential and intended only for the use of Midsouth Bariatrics.

_____

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_____

Name _____ DOB _____

# Health Questionnaire (George Woodman, MD) (cont'd)

## Diet History

Patient Name_____Date_____

Weight Watchers
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Nutri-Systems
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Optifast
Dates_____ How many times_____Wt lost_____ Wt Regained_____
TOPS
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Mayo Clinic Diet
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Cambridge
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Dr Atkins'
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Weigh Down Workshop
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Jenny Craig
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Slim Fast
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Medifast
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Protein
Dates_____ How many times_____Wt lost_____ Wt Regained_____

Other_____
Dates_____ How many times_____Wt lost_____ Wt Regained_____

Other_____
Dates_____ How many times_____Wt lost_____ Wt Regained_____

Medications:
Phentermine_____Redux_____Fastin_____Adipex_____Dexatrim_____Others_____
Psychotherapy
Dates_____ How many times_____Wt lost_____ Wt Regained_____
Hypnosis/Acupuncture
Dates_____ How many times_____Wt lost_____ Wt Regained_____

Other_____

Dates_____ How many times_____Wt lost_____ Wt Regain_____

Other_____

Dates_____ How many times_____Wt lost_____ Wt Regain_____