Patient Health History

Please, complete this health history to the best of your ability. The more complete and accurate it is the more it will help us plan your treatment.

Bring completed Health History to your first appointment.

If you have questions while filling out the Health History, call 314-338-7970 and ask to speak with a patient advocate.

St. Alexius NewStart
1400 Lemay Ferry Rd
St. Louis, MO 63125
Phone: 314-338-7970 Fax: 314-544-8099

Health History

Date: ____________

_____________________ Last Name

_____________________ First Name

____________ Date or Birth

______ Age

_______ Height

_______ Weight

________________ How long at current weight?

___________________ Occupation

Employment Status:
__ Full Time __ Part Time __ Self-Employed __ Home Maker
__ Student __ Retired __ Unemployed __ Not Specified

Marital Status: (circle one)
M S W D

Race: __ White __Black __ Asian __Native American __ Other
Ethnicity: Hispanic Yes No

Who is the person to notify immediately following surgery?

NAME: ______________________________ RELATIONSHIP: ______________________

PHONE: Home: ________________________ Cell or Other: ________________________

Will they be waiting at the hospital during your surgery? ______________________________

PRIMARY HEALTH CARE PROVIDER- Who is your primary physician, nurse practitioner, etc?

NAME: ____

ADDRESS: ____

City __________________ State ______ Zip Code ____________

PHONE: _________________________ FAX: _________________________

How long have they provided medical care for you? ________

If less than 2 years, who was your previous primary physician? _________________________

OTHER TREATING PHYSICIANS- List any other doctor you see on a regular basis.

Name	Phone Number	Specialty

LIST ANY SURGICAL HISTORY Please indicate if it was done laparoscopically with an *

HAVE YOU EVER HAD SURGERY TO AID IN WEIGHTLOSS? YES NO (circle one)

Surgery	Date	Reason	Hospital

NAME: ___________________________

MEDICATIONS- List any medications you are currently taking.

Name	Strength	Frequency	Reason you take it?	When did you start?

Are you allergic to any Medicine or foods? __ yes __ no

Please list drug/food and your reaction:

____

____

FAMILY HISTORY -Check all that apply for each family member.

Family Member	**Age now or at death**	**Cause of death**	**High Blood Pressure**	**Heart Problems**	**Diabetes**	**Stroke**	**Cancer**	**Obesity**
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Sibling 1								
Sibling 2								
Sibling 3								

NAME: ______________________________

Please answer all of the following questions related to your current or past medical history.

CARDIOVASCULAR SYSTEM:

	YES	NO			YES	NO
Hypertension (high blood pressure)				Shortness of breath		
Chest pain or angina				Fatigue		
Irregular or rapid heart heart rate				Leg ulcers		
Congestive Heart Failure				Blood clots in legs		
Heart murmur				Varicose veins		
Mitral valve prolapse				Ankle edema (swelling of legs and feet)		
High cholesterol or triglycerides						
Do you see a cardiologist?			If yes, name and number:			
Have you had an EKG?			If yes, where and when:			
Have you had a stress test or echo? (circle)			If yes, where and when:			
Have you had a cardiac catheterization?			If yes, where and when:			
Have you had heart surgery?			If yes, where and when:			

ENDOCRINE SYSTEM:

	YES	NO			YES	NO
Diabetes (Type 1 or Type 2) Circle One				Hypoglycemia (low blood sugars)		
Gestational Diabetes (with pregnancy)				Hypothyroidism or thyroid problems		
Insulin resistance (elevated blood sugars)						

RESPIRATORY SYSTEM:

	YES	NO			YES	NO
Shortness of Breath with activity				Sleep Apnea (stop breathing while asleep)		
Snoring				If yes, have you have you had a sleep study?		
Frequent awakening to catch breath				Do you use a C-PAP or BI-PAP? (circle one)		
Asthma				Pneumonia		
If yes, date of last attack?				Blood clot in lungs?		
Bronchitis				If yes, do you have a vena cava filter?		
If yes, number of events in the last 2 years?				Are you on blood thinners?		
Emphysema or COPD						

GASTROINTESTINAL SYSTEM:

	YES	NO			YES	NO
Stomach Ulcer				Gallbladder Problems		
If yes, when and type of treatment?				If yes, has your gallbladder been removed? When?		
GERD or heartburn?				Have you had x-rays showing gallstones? If yes, please send a copy of the report.		
Inflammatory bowel disease Such as, Crohn's or ulcerative colitis.				Irritable bowel syndrome		

NAME: ______________________

MUSCULOSKELETAL SYSTEM:

	YES	NO		YES	NO
Arthritis			Have you been treated by a chiropractor?		
Degenerative Disc Disease			Lupus		
Joint Pain			Do you take anti-inflammatory medication		
If yes, circle affected areas. Neck Hands Back Hips Knee Ankles Feet			If yes, list them here:		
Have you had a joint replacement?			Have you had back surgery?		
If yes, when?			If yes, when?		
Fibromyalgia			Have you had physical therapy?		
			If yes, when?		

GENITOURINARY SYSTEM:

	YES	NO		YES	NO
Urinary Stress Incontinence (loss of urine with coughing, sneezing, laughing)			Polycystic Ovarian Syndrome		
Irregular Menstrual Cycle			Menopause		
Heavy Menstrual Cycle			Hysterectomy		
Infertility			Do you use birth control?		

It is STRONGLY recommended that female patients begin using birth control prior to surgery. Weight loss may improve fertility.

NEUROPSYCHOLOGICAL SYSTEM:

	YES	NO		YES	NO
Stroke			Schizophrenia		
If yes, any paralysis? YES NO If yes, where?			History of drug abuse		
Transient Ischemic Attack (TIA)			History of alcohol abuse		
Seizures			If yes, how long alcohol free?		
Headaches			Eating disorders?		
Depression			If yes, please circle: Anorexia Nervosa, Bulimia, Compulsive Overeating		
Anxiety			If yes, were you treated?		
Bipolar Disorder			If yes, when and where?		

Other:

	YES	NO		YES	NO
Do you have any hearing impairment?			Do you wear glasses?		
Do you wear a hearing aid?			Do you wear contact lenses?		
Do you have dentures?			Do you exercise?		
Do you smoke?			If yes, what type?		
If yes, how many packs per day?			If yes, how many times per week?		
If no, did you ever smoke?			If no, what prevents you from exercising?		
When did you quit?			Do you require any aides for mobility?		
YOU WILL BE ASKED TO QUIT SMOKING BEFORE SURGERY TO DECREASE YOUR SURGICAL RISKS.			If yes, circle one: Cane Walker Wheelchair		
			Do you have any religious preferences that affect your healthcare?		

NAME: ______________________________

WEIGHT AND DIET HISTORY:

NAME: ______________________________

Many insurance companies request a history of your previous weight loss attempts. This portion of your health history will help us gather that information. In addition, so insurance companies will request physician supervised weight loss attempts. If you have attempted this in the past please have those notes sent to us to expedite your surgery. Your patient advocate will discuss more of this with you.

HISTORY:

	Current Weight _________lbs	Height ________in	
Weight 1 year ago _________lbs	Weight in high school _________lbs	Highest Weight _________lbs	When: ___________

LIFESTYLE:

How many years have you been more than 75 pounds overweight?	
At what age did you begin your first diet?	
Were you considered overweight as a child?	
What is your lowest weight since you were 18 years old?	
How long have you actively been attempting to lose weight?	
What is the greatest amount of weight you have lost?	
How did you accomplish that weight loss?	
How long were you able to maintain that weight loss?	
How many times per day do you eat?	
What are your favorite foods?	
Are you a snacker? YES NO If yes, what are your favorite snacks?	
Do you eat sweets? YES NO If yes, how often?	
Do you drink alcoholic beverages? YES NO If yes, how many drinks per week?	
Do you use Caffeine? (Coffee, colas, chocolate, energy drinks, or pills) If yes, what type? If yes, how much per day?	

EATING HABITS: Do you eat due to these? Circle yes or no to the below question.

Binge	Purge	Stress Eating	Loneliness	Boredom
Yes No	Yes No	Yes No	Yes No	Yes No

Have you tried any of the following for weight loss?

PHYSICIAN SUPERVISED	When did you try it?	For how long?	Number of pounds lost?
Behavior Therapy			
Psychology			
Acupuncture			
Hypnosis			
Fitness Center			
Exercise Programs			

DIET ATTEMPTS: This section lists common commercial and supervised diet plans.
Please, answer to the best of your ability. NAME:____________________

PHYSICIAN SUPERVISED	When did you try it?	For how long?	Number of pounds lost?
Example: NewStart Diet	1/1/14 to 6/30/14	6 months	20 lbs
Medifast			
Optifast			
Redux			
Pondimin			
Fen/Phen			
Phentermine/Fastin/Adipex			
Meridia			
Xenical			
HMR			
Qsymia			
Other: ____________			
With a physician: Dr. ____________			
ORGANIZED DIET PLANS	When did you try it?	For how long?	Number of pounds lost?
Weight Watchers			
Jenny Craig			
LA Weight Loss			
Nutrisystem			
TOPS			
Overeaters Anonymous			
American Diabetes Association			
Other: ____________			
SELF PLANNED	When did you try it?	For how long?	Number of pounds lost?
Trim Spa			
Accutrim			
Cortaslim			
Body Solutions			
Dexatrim			
Diurex			
Relacore			
Alli			
Ayds			
Atkins			
Grapefruit Diet			
Cabbage Soup Diet			
Cambridge Diet			
South Beach Diet			
Air Force Diet			
The Zone Diet			
Richard Simmons Diet			
Low Calorie Diet			
Low Fat Diet			
Herbal Diet			
Self-imposed fast			
Other: ____________			