Stella Maris
Internal Medicine &
Center for Medical Weight Loss

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HEALTH QUESTIONNAIRE

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

Please complete this form to the best of your ability prior to your office visit and bring it with you so we can review it during your exam. If there are any questions you prefer not to answer on paper, we can discuss them in person. Additional space on the back can be used if necessary.

Please explain your reason for having this examination._____
_____
_____

Have you had an evaluation of the condition you indicated? ___No ___ Yes
If so what type, when, and by whom? _____
_____
_____

What type of treatment have you received? _____
_____
_____

MEDICATIONS: List all medicines you take regularly or use on an as needed basis. Include both prescription medicines as well as over-the-counter medicines (including pain medicine, diet pills, laxatives, vitamins, herbal remedies, etc.).

Name of Medication	Dosage/Strength	Times Per Day	Reason

Are you allergic to any medications? **___No ___Yes**

Name of Medication	Reaction

Past Medical History
List any significant medical conditions (and year it began) you have currently or have had in the past.

Year	Description of Illness

List all hospitalizations, operations/surgeries, and major diagnostic testing you have been through.

Year	Reason for hospitalization, operation or test	Name of Hospital	City/State

SOCIAL HISTORY:

Marital Status: □ Single □ Married □ Divorced □ Widowed
Children: □ Boys_____ □ Girls _____

Occupation: _____ Employer: _____

Use of Alcohol: □ Never □ Socially □ Rarely □ Occasionally □ Daily
What type of alcohol do you consume? _____
More than 5 drinks per week? Yes No

Use of Tobacco: □ Never □ Previously but quit □ Do you smoke now? Yes No
Current packs per day _____ When did you quit? _____
How long did you smoke? _____ Previous packs per day _____

Use of Drugs: □ Never □ Previously but quit
Type/Frequency _____
Are you currently using any recreational/illegal drugs? Yes No

FAMILY MEDICAL HISTORY:

	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Sisters	____	_____	_____
	____	_____	_____
Brothers	____	_____	_____
	____	_____	_____
Children	____	_____	_____

HEALTH HISTORY:

Mark if you have experienced any of the following and indicate the year it occurred.

Heart/Circulatory Problems	No	Yes	Year
Do you have angina or chest pain?			
Have you had a heart attack?			
Have you ever had high blood pressure?			
Do you have a heart murmur?			
Have you ever had an irregular heart beat or palpitations?			
Have you had rheumatic fever?			
Do you ever have swollen legs or ankles?			
Do you ever have leg cramps?			
Have you ever had a blood clot?			

Endocrine Problems	No	Yes	Year
Do you have diabetes?			
Have you ever had thyroid problems?			

Lung Problems	No	Yes	Year
Do you have shortness of breath? At rest? With exertion?			
Do you have chronic cough or emphysema?			
Have you ever had pneumonia?			
Do you ever cough up blood?			
Do you ever have asthma or wheezing?			
Have you ever been exposed or infected with tuberculosis (TB)?			
Have you ever been tested for tuberculosis?			
Have you ever had an abnormal chest x-ray?			

Digestive/Bowel problems	No	Yes	Year
Have you had a change in bowel habits?			
Have you had blood in the stool or passed black stools?			
Do you have problems with diarrhea or constipation?			
Have you had any unusual weight gain or loss?			
Have you ever had an ulcer, frequent heartburn or indigestion?			
Do you have problems with frequent nausea or vomiting?			
Do you have diverticulosis?			
Have you ever had colitis?			
Have you ever had a colonoscopy or sigmoidoscopy?			

Skin	No	Yes	Year
Do you have a rash or itching?			
Have you had a change in skin color?			
Do you have a change in hair or nails?			
Do you have varicose veins?			
Do you have breast pain, breast lumps, or breast discharge			

Genitourinary	No	Yes	Year
Have you had frequent urination or change in force of strain when urinating?			
Have you had burning or painful urination?			
Have you had blood in urine?			
Have you had any incontinence or dribbling?			
Do you have a history of kidney stones?			
Do you have sexual dysfunction?			
Male-Do you have testicle pain?			
Female-Do you have painful periods, irregular periods, or vaginal discharge? Date of last Pap smear _____□ Normal □ Abnormal			
Female-# of pregnancies _____ # miscarriages _____			

Musculoskeletal	No	Yes	Year
Have you had joint pain?			
Have you had joint stiffness or swelling?			
Have you had weakness of the muscles or joints?			
Have you had muscle pain or cramps?			
Have you ever had back pain?			
Do you have difficulty walking?			

Neurologic	No	Yes	Year
Do you have frequent or recurring headaches?			
Do you have lightheadedness or dizziness?			
Have you had convulsions or seizures?			
Do you have tremors?			
Have you had paralysis?			
Do you have a history of a stroke?			
Do you have a history of a head injury?			
Have you had memory loss or confusion?			

Psychiatric	No	Yes	Year
Do you have nervousness?			
Have you had depression?			
Do you have any sleep problems?			

Endocrine	No	Yes	Year
Do you have a history of glandular or hormone problem?			
Have you had thyroid disease?			
Have you had diabetes?			
Do you have excessive thirst or frequent urination?			
Do you have heat or cold intolerance?			
Do you have dry skin?			
Have you had a change in your hat or glove size?			

Hematologic/Immunologic	No	Yes	Year
Do you have a history of skin reactions or other adverse reactions?			
Penicillin or other antibiotics?			
Morphine, Demerol, or other narcotics?			
Novocain or other anesthetics?			
Aspirin or other pain remedies?			
Tetanus antitoxin or other serums?			
Iodine, methiolate, or other antiseptic?			
Other drugs/medications _____			
Known food allergies_____			

Describe any particular problem or symptom that was not covered by this questionnaire

_____

_____

What are your major health concerns?

_____

_____

What are your major health goals?

_____

_____

Name of Pharmacy_____
Pharmacy Phone#_____ **Pharmacy Fax#**_____
Pharmacy Address_____

Treating Physician(s):_____
Phone number of physician(s):_____
Physician(s) Address:_____
_____

I, _____, hereby authorize Hani C. Soudah, MD, PhD, FACP and/or Melissa Patz, PA-C to contact any of my treating physicians regarding my medical conditions.

_____ _____
Signature **Date**

DIET HISTORY

Age you first started dieting: _____ Approximate weight at age 18 _____

Height: _____ Current Weight: _____ Weight range last 5 years _____ to _____

Program	Yes	No	Date(s)	Duration	Max Loss	MD Supervised?
Jenny Craig						
Nutrisystem						
Weight Watchers						
Optifast/Medifast						
O.A. or Tops						
Fen/Phen or Redux						
Phentermine						
Meridia						
Xenical						
Over the Counter Diet Aids						
Atkins Diet						
Other:						
Other:						

What was the most successful weight loss you have achieved and how did you do it? _____

_____

What behaviors did you learn from dieting that you still use today? _____

_____

Do you eat sweets? Yes No If so, what? _____

How often? _____

Do you eat pasta/bread? Yes No If so, what? _____

How often? _____

Do you eat fast food? Yes No If so, what? _____

How often? _____

Do you snack between meals? Yes No If so, what do you snack on? _____

How often? _____

Is snacking from habit? Yes No Is snacking from boredom? Yes No Do you binge eat? Yes No

How often? _____

What beverages do you consume throughout the day? _____

Quantity? _____

SOCIAL/FAMILY HISTORY:

Is there Obesity in the family: Yes No Who? _____

Other medical illness within the family? If so, what? Diabetes Hypertension Coronary Artery Disease

Other _____

Do you exercise regularly? Yes No If so, what do you do? _____

_____

Do you have any physical restrictions that keep you from exercising? Yes No Explain _____

_____

Do you have a history of abuse? (Please include emotional, physical, mental, substance or other types of abuse issues you have dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan.) _____

_____

_____

Describe your present life stressors: _____

_____

_____

Describe the present support system you rely upon. (Church, spouse, family, friends, co-workers, etc.): _____

_____

_____

Name: _____ SSN: _____ DOB: _____