



SURGICAL WEIGHT MANAGEMENT ASSOCIATES,LLC.

www.surgicalweightmanagement.com

Fritz Rau MD
David Rau MD
Eric Rau MD
Donald Schwab Jr MD

5619 Hwy 311 Ste B
Houma LA 70360
Phone (985) 68-2206
Fax (985) 868-2232

GENERAL HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Patient Name _____ Today's Date _____

Birth Date _____ Social Security Number _____

Street Address, City, State, Zip _____

Mailing Address (if different) _____

Home Phone _____ Work _____ Cell _____

Gender Male Female Marital Status Married Single Divorced Widowed

Race Caucasian Asian African American Hispanic Native American Hawaiian Other

Email Address _____

Employer _____

Occupation _____ Status(Full/PartTime,Retired,etc) _____

Emergency Contact Name (Not living with you) _____

Relationship _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Name	Name
Phone #	Phone
Policy	Policy
Group	Group
Subscriber Name	Subscriber Name
Relation to Pt & DOB	Relation to Pt & DOB
Subscriber SSN	Subscriber SSN
Subscriber Employer	Subscriber Employer

PRIMARY CARE / FAMILY PHYSICIAN INFORMATION

Name _____

Address, City, State, Zip _____

Office Phone # _____ Fax # _____

WHO REFERRED YOU TO US? _____

BODY SIZE & WEIGHT INFORMATION

Height _____ Weight _____ BMI _____

WEIGHT LOSS HISTORY

How long have you been overweight? _____

LIST ANY PHYSICIANS WHO HAVE TREATED YOU FOR DIET:

Name _____ Phone # _____

When (Year) _____ Duration _____

Name _____ Phone # _____

When (Year) _____ Duration _____

CHECK ANY DIET PROGRAMS YOU HAVE ATTEMPTED. NOTE THE DATES OF EACH DIET PROGRAM AND HOW MUCH WEIGHT WAS LOST.

_____ PhenFen	_____ Yrs	_____ lbs lost	_____ Redux	_____ Yrs	_____ lbs lost
_____ Pondamin	_____ Yrs	_____ lbs lost	_____ Meridia	_____ Yrs	_____ lbs lost
_____ TOPS	_____ Yrs	_____ lbs lost	_____ Xenical	_____ Yrs	_____ lbs lost
_____ Nutri-system	_____ Yrs	_____ lbs lost	_____ Weight Watchers	_____ Yrs	_____ lbs lost
_____ Jenny Craig	_____ Yrs	_____ lbs lost	_____ Slimfast	_____ Yrs	_____ lbs lost
_____ Metabolife	_____ Yrs	_____ lbs lost	_____ South Beach	_____ Yrs	_____ lbs lost
_____ Atkins	_____ Yrs	_____ lbs lost			

LIST ANY OTHER DIET OR EXERCISE PROGRAMS, DATES, & WEIGHT LOST.

Have you had prior surgery for weight loss? Yes No Type _____ Date _____

MEDICAL/SURGICAL HISTORY

CURRENT MEDICATIONS/VITAMINS & MINERALS (prescription and non-prescription)

Medication	Dose	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Multiple Vitamin Calcium Vitamin B-12 Iron Vitamin D Vitamin A,D,E Calcium with Vitamin D

ALLERGIES (list all allergies including medication allergies and reactions)

MEDICAL HISTORY (please mark all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes Type ____, on Insulin | <input type="checkbox"/> Diabetes Type ____, Non-Insulin | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Attack (MI) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Congestive Heart Failure Class _____ |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin Breakdown |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> GERD | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Stomach/Bowel Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> TIA (transient ischemic attack) |
| <input type="checkbox"/> Crohn’s Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Pancreas Problems |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> DVT/Pulmonary Embolus | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Anxiety/panic disorder | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> Psychosis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> HIV/AIDS |

Describe all medical problems:

SLEEP HISTORY

	Frequently	Sometimes	Never
Do you wake up gasping for breath?			
Do you awaken with headaches?			
Do you fall asleep while reading?			
Do you have heartburn or “reflux” while sleeping?			
Do you have difficulty falling asleep or staying asleep?			
Do you wake up with a dry mouth, sore throat, or headache in the morning?			
	Yes	No	
Do you use a CPAP or BiPAP?			
Have you ever been to a sleep lab for treatment or evaluation?			

SURGICAL HISTORY (please mark all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy (Gallbladder) | <input type="checkbox"/> Bowel resection |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Breast Cancer, radiation | <input type="checkbox"/> Breast Cancer, mastectomy | <input type="checkbox"/> Breast cancer, biopsy |
| <input type="checkbox"/> Anti-reflux procedure | <input type="checkbox"/> Peripheral Vascular procedure | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Bowel resection | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Discectomy |

List all surgeries and approximate dates:

FAMILY HISTORY

Condition	Father	Mother	Father's Parent	Mother's Parent	Sibling
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Bleeding Disorder					
Kidney Disease					
Thyroid Disease					
Arthritis					
Early Death Cause of Death					

SOCIAL HISTORY

Alcohol Use None Rare Occasional Frequent

Substance Abuse None Rare Occasional Frequent

Tobacco Use None Rare Occasional Frequent

If you smoke or use tobacco, how much per day? _____

Past tobacco user? No Yes # Years _____ When did you quit? _____

MENSTRUAL HISTORY

Date of last menstrual period _____ Could you be pregnant? _____

Date of last pregnancy _____ Number of pregnancies _____

Irregular periods Menorrhagia (heavy periods) Amenorrhea (absence of menstrual periods)

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY OF THE FOLLOWING WITH WHICH YOU HAVE HAD SIGNIFICANT PROBLEMS IN THE PAST.

■ **GENERAL** Weakness Fatigue Fever Chills Sweats Weight Gain Weight loss Anemia

■ **NEUROLOGICAL** Headache Dizziness Weakness Numbness Seizures Tremors Memory Changes
 Fainting Unsteady gait Speech Problems Nervousness Disorientation
 Behavioral Changes

■ **PSYCHIATRIC** Anxiety Depression Mood Swings Hallucinations Difficulty Sleeping Alcohol Abuse

■ **EYES** Blurred Vision Double Vision Blindness Pain Retina Problems Cataracts Glaucoma

■ **EARS** Ringing Pain Frequent Discharge Drainage

■ **NOSE** Bleeding Sinus Problems Pain Frequent Infections

■ **THROAT** Pain Hoarseness Ulcers Difficulty Swallowing Tooth Pain Frequent Infections
Bleeding Gums

■ **ENDOCRINE** Hypothyroidism Hyperthyroidism Heat or Cold Intolerance Frequent Urination
Constant Thirst

■ **LUNGS** Chronic Cough Wheezing Shortness of Breath Congestion Coughing up Blood Sputum

■ **CARDIOVASCULAR** Chest Pain Chest Tightness High Blood Pressure High Triglycerides Palpitations
Mitral Valve Prolapse Heart Murmur Heart Attack Blood Clots Shortness of breath
Shortness of breath while lying flat Ankle Swelling Lower extremity edema
Venous Stasis (Leg) Ulcers

■ **GASTROINTESTINAL** Abdominal Pain Nausea Vomiting Diarrhea Heartburn Constipation Ulcers
Blood in stool Difficulty Swallowing Rectal pain Loss of Appetite Gallstones
Changes in bowel pattern Rectal Bleeding Hemorrhoids Excessive thirst Colitis

■ **URINARY** Frequency Urgency Discharge Pain with urination Menstrual Problems Blood in urine
Prostrate Problems Frequent urinary tract infections

■ **MUSCULOSKELETAL** Back pain Joint pain Joint Swelling Muscle Pain Decreased range of motion
Plantar Fasciitis

■ **SKIN** Rashes Burning Itching Swelling Moles Bruise Easily Change in Hair/Nails

A medical clearance from your primary healthcare physician is required prior to surgery. Please have your doctor write a letter of medical necessity stating how long you've been treated, the duration of your obesity, and that you are medically cleared for surgery.

Note: Please sign and date. This questionnaire will become a part of your medical chart.

Patient Signature

Date