



# 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