High Quality Solutions LLC
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Diabetes Obesity CLINIC

Health Questionnaire

The information you provide will help us to plan your tratment, please carefully fill it out.

PATIENT INFORMATION

LOCATION: Tijuana **SURGEON:** _____

NAME _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____
EMAIL ADDRESS _____ **OCCUPATION** _____
DATE OF BIRTH _____
GENDER **MALE** _____ **FEMALE** _____
SINGLE _____ **MARRIED** _____ **DIVORCED** _____
SEPARATED _____ **WIDOW/WIDOWER** _____

Age		**MEASUREMENTS**	**CURRENT SIZE**
Height		**Neck**	**SHIRT /T SHIRT / BLOUSE**
Weight		**Wrist**	**PANTS / JEANS**
BMI		**Waist**	
		Hip	
		Thigh	

PROCEDURE

Please indicate which procedure you are interested in

Gastric Balloon		**SUGGESTED DATE**	
Sleeve Gastrectomy		Do you have any date on mind to have your procedure?	
RNY			
Mini Bypass			
Revision			
Plastic Surgery		Details:	
Other		Details:	

REFERRAL INFORMATION

Referring person: _____
Date of Referral: _____

EMERGENCY CONTACT INFO

NAME _____
CELL PHONE NUMBER _____

PRIMARY HELATH CARE PROVIDER

Name: _____
Phone: _____ Email: _____
How long has he/she trated you? _____
Condition treated? _____
If you are under the care of other physicionas, please provide details:

_____

ALLERGY

Are you allergic to any MEDICATION? **Yes** _____ **No** _____
Please list: _____
Are you allergic to any WOUND CARE SUPPLIES (tape, latex, isodine, alcohol, merthiolate, talcum powder, etc)?
Yes _____ **No** _____
Please list: _____
Are you allergic to any FOOD (fruits, vegetables, seeds, meat, fish, egg, dairy, etc)?
Yes _____ **No** _____
Please list: _____

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CURRENT MEDICATION (Include vitamins, over the counter medication, etc)

Name of medication	Dose	How often taken	Purpose	When use started	Check the appropiate box Required as needed

LIST OF ANY MAJOR ILLNESSES

DATE	ILLNESS	TREATMENT	OUTCOME

LIST ANY SURGERIES

SURGERY	DATE	REASON	HOSPITAL

Have you ever had a blood transfusion? **Yes** _____ **No** _____

When and details: _____

OTHER HOSPITALIZATIONS

DATE	REASON	HOSPITAL

FAMILY HISTORY

FAMILY MEMBER	AGE	CAUSE OF DEATH	CHECK ALL THAT APPLY				HEALTH PROBLEMS
			THIN	NORMAL WEIGHT	SLIGHTLY OVERWIEGHT	MODERATELY OVERWEIGHT	

What other family members have or have had (indicate mother´s / father´s side of your family):

Breast, Colon or Prostate Cancer: _____
Cancer (specify type): _____
Diabetes: _____
Heart attack: _____
Stroke: _____
High Blood Pressure: _____
Arthritis or back trouble: _____
Obesity: _____

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RESPIRATORY SYSTEM

Do you experience shortness of breath with physical activity? YES NO

How long have you been aware of this? MONTHS _____ YEARS _____

Do you excercise regularly? YES _____ NO _____

do you have or have you had asthma? YES _____ NO _____

SLEEP EVALUATION

Do you snore? YES _____ NO _____

On average, how many hours you sleep every day? _____

When you wake up, do you feel tired? YES _____ NO _____

During the day, are you tired or sleepy? YES _____ NO _____

Do you use CPAP? YES _____ NO _____

BLOOD AND CIRCULATORY SYSTEM

Do you experience swelling of the ankles? YES _____ NO _____

What do you do to decrease the swelling? _____

What do you take to relieve the pain? _____

ENDOCRINOLOGY SYSTEM

Thyroid problems? YES _____ NO _____

Are you diabetic? YES _____ NO _____ How long? _____

What are you taking for your diabetes?

Do you monitor your blood sugar? Yes / No _____ How often? _____

Have you been diagnosed with PCOS? YES _____ NO _____

CARDIAC SYSTEM

Do you have high blood pressure? _____

What are you raking for your high blood pressure? _____

Do you experience chest pain? Yes / No _____ How often? _____

Do you have any history of heart disease? YES _____ NO _____

Explain: _____

Have you had a heart attack? YES _____ NO _____

HEPATIC SYSTEM

Have you diagnosed with fay liver, cirrhosis, hepatitis or any liver disease?

YES _____ NO _____

Details: _____

AUTO IMMUNE SYSTEM

Have you been diagnosed with Rheumatoid Arthritis? YES NO

Are you taking or have you taken nonsteroidal anti-inflammatory drugs (NSAIDs) for joint pain?

YES _____ NO _____

Have you been diagnosed for Lupus? YES _____ NO _____

have you been diagnosed as HIV positive? YES _____ NO _____

ANY OTHER (Multiple Sclerosis, Fibromyalgia, E YES _____ NO _____

DIGESTION PROBLEMS

Do you regularly have constipation? YES _____ NO _____

Have you been diagnosed with diverticulitis? YES _____ NO _____

Do you any history of ulcers? YES _____ NO _____

Have you been disgnosed with Crohn´s disease or Ulcerative Colitis? YES NO

Do you have indigestion or heartburn? YES _____ NO _____

If so, for how long _____ years / months

What foods or drinks cause digestive problems for you?

Food / Drink	Result of eating / drinking

Do you ever have any type or pain in the abdomen? YES NO

Pain details (sharp, dull, hot, cold, aching, crushing, etc) _____

Any changes in bowel movements? YES _____ NO _____
Any bloody stools? YES _____ NO _____ History of hemorrhoids? _____

MENTAL HEALTH

Have you ever been treated for an eating disorder? YES NO
Are generally happy with your life other than your weight? YES NO
Do you have a history of depression? YES NO
Do you feel depressed? YES NO
Is stress a major problem for you? YES NO
Do you panic when stressed? YES NO
Do you have problems with eating or your appetite? YES NO
Do you cry frequently? YES NO
Have you ever attempted suicide? YES NO
Have you ever seriously thought about hurting yourself? YES NO
Do you have trouble sleeping? YES NO
Have you ever been to a counselor? YES NO

ALCOHOL

Do you drink alcohol? YES NO
If yes, what kind? _____ Frecuency? _____
How many drinks per week? _____
How do you drink it? Plain Mixed
When is mixed, what do you prefer? Soda Juice Carbonated water
Do you eat something when you are drinking? YES NO
What do you usually eat? _____
Are you concerned about the amount you drink? YES NO
Have you considered stopping? YES NO
Have you ever experienced blackouts? YES NO

TOBACCO

Do you use tobacco? YES NO
Cigarettes - pks./day _____ Chew - #/day _____ Pipe- #/day _____
Cigars - #/day _____ _____ # of years _____ Or Year Quit

CAFFEINE

Do you use caffeine (coffee, cola, chocolate, energetic beverages) YES NO
If yes, in what form? _____ How much per day? _____
In one day, what is the volume of liquid that you are drinking of?
Carbonated How many? _____ Brand _____
Sugary How many? _____ Brand _____
Natural How many? _____ Brand _____
With Caffeine How many? _____ Brand _____

DRUGS

Do you currently use recreational or street dru YES _____ NO _____
If yes, please give details: _____
Have you ever giben yourself street drugs with a needle?
YES _____ NO _____

SEX

Are you sexually active? YES _____ NO _____
If yes, are you trying for a pregnancy? YES _____ NO _____
If not, trying for a pregnancy list contraceptive or barrier mehod used

_____

Any discomfort with intercourse? YES _____ NO _____

Illnes related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illmess include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illmess?

YES _____ NO _____

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BONE OR JOINT PROBLEM

Do you have any of the following?

Location	Swelling	Pain	Stiffness	Popping Crackling
Ankles				
Knees				
Hips				
Back				
Others				

Have you ever sought treatment for bone or joint problems or injuries? Give details below (include physical therapy and chiropractic)

Doctor	Date of Treatment	Diagnosis / Treatment

Have you taken any medications for this problem? _____

If so what: _____

Have you ever been told that you have degenerative changes? _____

or early arthritic changes in you joints? _____

Details: _____

DIET HISTORY

Have you ever had surgery to aid in weight loss **YES** _____ **NO** _____

How long have you been overweight? _____

Have you tried diet pills? YES _____ NO _____

Which diet programs have you tried? Check the following diet programs that apply to you:

Diet medication	**Medifast**	**Rader Institute**
Prikin diet	**Living Well Lady**	**Hypnosis**
Slim Fast	**Topfast**	**Optifast**
Low-Calorie- Diet	**Jenny Craig**	**air force Diet**
Subliminal tapes	**Overeaters anonymus**	**Diet Center**
Physician Supervised Diet	**Numerous Book Diets**	**Self-imposed fasts**
High- Protein Diet	**Virginia Mason Clinic**	**Cabrini Eating disorder**
Weight Watchers	**Mayo Clinic**	**Other**
Herbal Life	**Tops**	

How much weight did you lose with the diet program (s)? _____

How quickly did you regain the weight afterwards? _____

What has been your MAXIMUM WEIGHT? _____ How long was that?

What has been your MINIMUM WEIGHT? _____ How long was that?

How much weight are you expecting to lose? In how many time?

Enlist the food your like the most and the food you dislike the most

LIKE: _____

DISLIKE: _____

Are you snacker? YES _____ NO _____

Are you a volume eater? YES _____ NO _____

Do you eat a lot of sweets? YES _____ NO _____

How often do you eat sweets? _____

Do you frequently eat fast food and/or do you drink carbonated beverages? _____

EXERCISE

Please select the option that best suits your lifestyle

Sedentary (No excercise) _____

Mild excercise: _____

(i.e., daily activity, domestic work, go to the market, walk the dog, climb stairs, walk 3 blocks, golf)

Occasional vigorous exercise (i.e. work or recreation, less than 120 min/week) _____

Regular vigorous exercise (i.e. work or recreation more than 120 min/week) _____

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REVIEW OF SYSTEMS: Unless otherwise specified, mark the correct box and provide any information about your current status.

	YES	NO	DETAILS OR COMMENTS
FREQUENT OR SEVERE FATIGUE			
FREQUENT OR SEVERE WEAKNESS			
FEVER, CHILLS OR NIGHT SWEATS			
FREQUENT OR SEVERE HEADACHES			
ANY HISTORY OF HEAD INJURY WITH LOSS OF CONSCIOUSNESS			
HEARING PROBLEMS			
EAR PAIN			
NASAL CONGESTION			
CHRONIC SINUS CONGESTION			
FREQUENT BLOODY NOSE			
DENTALS PROBLEMS			
DENTURES			
SORES IN MOUTH			
WHEEZING			
COUGHING			
BREAST LUMP, PAIN OR DISCHARGE			
HEART MURMUR			
HIGH BLOOD PRESSURE			
CHEST PAIN WITH EXCERCISE OR ACTIVITY			
ANY SEXUALLY TRANSMITTED DISEASE THAT WAS NOT TREATED			
ANEMIA			
BLEEDING TENDENCY			
CONVULSIONS, SEIZURES			
PARALYSIS			
NUMBNESS OR TINGLING			
MEMORY LOSS			
DEPRESSION			
ANXIETY			
MOOD SWINGS			
SLEEP PROBLEMS			
DRUG OR ALCOHOL ABUSE			
CHRONIC SKIN RASH OR HIVES			
ASTHMA			
HAY FEVER			

Please list any additional information you beleive would assist in your health planning

I understand that full disclosure is necessary to my medical safety, I have filled out this medical history to the best of my knowledge and I have answered these questions with complete honesty to insure my health and safety.

Patient Initials Date