NYU Langone Weight Management Program
MEDICAL QUESTIONNAIRE

Date: ______________________ **DOB:** ______________________ **Age:**______________

Last Name:______________________ **First Name:** ______________________

Medications- Please include **ALL** medications you take regularly (ALL vitamins, supplements or herbals)

Name of medication	Dose	How often	Start Year

Do you have **allergies to medications**? Yes / No

If yes, please list; ____

Do you have **an allergy to Latex**? Yes / No or Surgical tape? Yes / No

Do you have **allergies to food**? Yes / No

If yes, please list; ____

Prior Surgeries:	**Yes**	**No**
Previous coronary angioplasty or stents	Yes	No
Previous heart surgery	Yes	No
Please list other surgeries and indicate dates	**Date**	

Previous obesity surgery	Yes	No	
Date:		Hospital:	
Type of Surgery:		Surgeon:	
Weight at the time of surgery:	lbs	Reason for transfer of care:	

Medical History

Smoking History	Yes **(stopped date:)**	No	
	Current Smoking:	Yes	No
Alcohol	Yes (**how many glasses/wk:**)	No	
Diabetes	Yes	No	
High Blood Pressure	Yes	No	
GERD (Gastroesophageal Reflux Disease)	Yes	No	

Name: **Date:**

High Cholesterol (abnormal lipids)	Yes	No	
Heart Disease or Previous Heart Attack	Yes	No	
Asthma	Yes	No	
Arthritis	Yes	No	
Back Pain	Yes	No	
Legs ulcer or Reddish-brown legs	Yes	No	
Depression	Yes	No	
COPD (Chronic Obstructive Pulmonary Disease)	Yes	No	
	Severe symptoms:	Yes	No
	History of hospitalization due to COPD:	Yes	No
Pulmonary Embolism (blood clot in lungs)	Yes	No	
DVT (blood clot in legs)	Yes	No	
Stroke	Yes	No	
Gallstones/ Gallbladder disorder	Yes	No	
Polycystic Ovarian Syndrome	Yes	No	
Bleeding disorder	Yes	No	
Liver disorder	Yes	No	
Kidney disorder	Yes	No	
Thyroid disorder	Yes	No	
Seizure	Yes	No	
Use of scooter, wheelchair, or other device to move around	Yes	No	
Activities of daily living	Independent	Dependent (Total or Partial)	
	Requiring oxygen:	Yes	No
Obstructive Sleep Apnea	Yes	No	
	Sleep study done:	Yes	No
	CPAP required:	Yes	No

High Risk of Sleep Apnea (STOP-Bang Score)

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2. Do you often feel tired, fatigued, or sleepy during daytime?	Yes	No
3. Has anyone observed you stop breathing during your sleep?	Yes	No
4. Do you have or are you being treated for high blood pressure?	Yes	No

Any Other Medical History- Please list **ALL** other medical history

FAMILY HISTORY – Please mark "**x**" to all that apply

Family member	Obesity	Diabetes	Heart disease	High Blood Pressure	High Cholesterol	Cancer (indicate type)
Father						
Mother						
Grand parents						

Do you or any of your family members have a history of **a bleeding or clotting disorder**? Yes / No

Please list: ______________________________

Weight Loss History

How long have you been at your present weight? ______________ yrs

What did you weigh 5 years ago? _____________lbs

What is the most you have ever weighed in your adult life? ____________ lbs The least weight? ___________lbs

Name: **Date:**

Has a physician ever supervised your attempts to lose weight? Yes / No

Doctor/Clinic City: Treatment Dates: Type of Treatment:

____

Have you tried diet pills? Yes / No

If yes, please list:____

Please check all that you have tried **IN THE LAST 10 YEARS.**

	Year	**Weight Loss (lbs)**		**Year**	**Weight Loss (lbs)**
Atkins			Medifast		
Acupuncture			Nutrisystem		
Calorie Counting			Nutritionist		
Diet Center			Optifast		
Fad Diet			Overeaters Anonymous		
Herbal Diet			Pritikin		
Health Spa			Self Diet		
High Protein			Slim Fast		
Hypnosis			Start Fresh		
Jenny Craig			South Beach		
LA Diet			Weight Watchers		
Leder			Zone		
Low Carbohydrate					

Patient Signature:_______________________________________ **Date:** ______________

MD Reviewed: ____ **Date:** ________________