OLYMPIA ORTHOPAEDIC ASSOCIATES PLLC
Your Life in Motion

Patient Medical History Form

Today's Date: _____

PATIENT INFORMATION

Height: _____ Weight: _____ BMI: _____

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Dr.

Hearing impaired? Yes No Visually impaired? Yes No Other limitations? _____

Need an interpreter? Yes No

Marital Status: Single Married Divorced Separated Domestic Partner Widow

Birth date: _____ Age: _____ Sex: M F

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

What number do you prefer to be contacted: Home Cell Work

Email Address: _____

Occupation: _____Employer: _____

How active is your job? Very Active (heavy lifting, construction) Active (on your feet most of the day)
Mixed (some on feet, some seated) Sedentary (mostly seated)

PROGRAM INFORMATION

Are you interested in bariatric surgery? Yes No

Have you previously had bariatric surgery? Yes No

If YES: What type of surgery? _____ Who was your surgeon? _____

Which facility was this done? _____When? _____

Do you still follow up with your surgeon? _____

Who is your primary care provider? _____ Phone number: _____

Do you see any other healthcare providers? Yes No

If YES, list all provider names and conditions seen for:

_____

_____

Past/Present Medical History

Diabetes	Yes	No	Past	Present		Emphysema/COPD	Yes	No	Past	Present
	Good Control		Poor Control			Pneumonia	Yes	No	Past	Present
	Type 1		Type 2			Arthritis	Yes	No	Past	Present
Diabetes while pregnant	Yes	No	Past	Present		Where?				
Hypertension (High blood pressure)	Yes	No	Past	Present		Problems with anesthesia	Yes	No	Past	Present
High Cholesterol or triglycerides	Yes	No	Past	Present		Thrombophlebitis	Yes	No	Past	Present
Heart attack	Yes	No	Past	Present		Abnormal bleeding	Yes	No	Past	Present
Have pacemaker or defibrillator	Yes	No	Past	Present		Rheumatic fever	Yes	No	Past	Present
Congestive heart failure	Yes	No	Past	Present		Thyroid problems	Yes	No	Past	Present
Heart murmur	Yes	No	Past	Present		Tuberculosis	Yes	No	Past	Present
Ever taken Fen-Phen	Yes	No	Past	Present		Urinary tract infection	Yes	No	Past	Present
Varicose veins	Yes	No	Past	Present		Kidney disease	Yes	No	Past	Present
Blood clots in the legs	Yes	No	Past	Present		Bladder/kidney infections	Yes	No	Past	Present
Blood clots to the lungs/Pulmonary embolism	Yes	No	Past	Present		Hepatitis/cirrhosis	Yes	No	Past	Present
PCOS (polycystic ovarian syndrome	Yes	No	Past	Present		AIDS/HIV	Yes	No	Past	Present
Stroke	Yes	No	Past	Present		Do you have to take antibiotics before dental work?	Yes	No	Past	Present
Asthma	Yes	No	Past	Present		Colitis/enteritis/Crohn's disease	Yes	No	Past	Present
						Seizures	Yes	No	Past	Present

Past Surgical History (any with approximate date):

_____

_____

Psychiatric: Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential.

Please check all that apply:

Alcoholism/substance abuse Anorexia Anxiety Attempted suicide
Attention deficit disorder Eating disorder Bipolar disorder
Depression PTSD Schizophrenia/schizoaffective disorder
Sexual abuse (if yes, when_____) Mental/emotional abuse (if yes, when_____)

Physical abuse (if yes, when_____) Self-injury/cutting behavior
Other psychiatric illness or condition: _____
Have you ever had outpatient counseling? Yes No
If yes, for what condition? _____
Have you ever been hospitalized for psychiatric problems? Yes No
If yes, when? _____
Are you currently seeing a counselor/psychiatric professional? Yes No
If yes, who is this?_____
Have you ever been in an alcohol or substance abuse program? Yes No
If yes, when? _____
Are you currently taking medication for anxiety, depression, or any other mental health problem? Yes No
If yes, who is prescribing this? _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Family History

Are you adopted? Yes No

Parents(s): **Mother** Alive Deceased **Father** Alive Deceased

Sibling(s): Brother(s): How many alive? ____ How many deceased? ____

Sister(s): How many alive? ____ How many deceased? ____

Children: How many alive? ____ How many deceased? ____

Please complete the below if NOT adopted:

	Parent (s)		Sibling(s)	
	Mother	Father	Sister	Brother
Diabetes				
Heart Disease				
Hypertension				
Gallstones				
Obesity				
Sleep Apnea				
Asthma				
Cancer (specify)				
Depression				
High Cholesterol				
Osteoporosis				
Stroke				
Chemical dependency				
Alcohol abuse				
Bipolar disorder				
Anesthesia problems				
Schizophrenia				

Review of Systems

General		
Fevers	Yes	No
Sweats	Yes	No
Fatigue	Yes	No
Loss of appetite	Yes	No
Skin		
Rash	Yes	No
Acne	Yes	No
Skin cancer	Yes	No
Skin darkening	Yes	No
If yes, where?		
Vision		
Visual problems	Yes	No
Hearing		
Hearing Problems	Yes	No
Ear Ringing	Yes	No
Neurological		
Dizziness	Yes	No
Migraines	Yes	No
Frequent headaches	Yes	No
Memory loss	Yes	No
Shaking	Yes	No
Numbness	Yes	No
Incoordination	Yes	No
Genito-urinary		
Blood in urine	Yes	No
Vaginal infections	Yes	No
Stress urinary incontinence	Yes	No
Prostate infections	Yes	No
Pulmonary disease		
Short of breath on exertion	Yes	No
Hay fever	Yes	No
Bloody sputum	Yes	No
Persistent Cough	Yes	No
Infection		
Recurring infections	Yes	No
Skin infections	Yes	No
Exercise Limitations		
Mild	Yes	No
Moderate	Yes	No
Severe	Yes	No

Physical Activity Limitations		
Climbing stairs	Yes	No
Unusual fatigue	Yes	No
Airline travel	Yes	No
Lifting from floor	Yes	No
Tying shoelaces	Yes	No
Playing with children	Yes	No
Pain in joints		
Back	Yes	No
Hips	Yes	No
Knees	Yes	No
Feet	Yes	No
Gastrointestinal		
Heartburn/acid reflux	Yes	No
Heartburn/acid reflux (5+ years	Yes	No
EGD/Stomach Scope	Yes	No
If yes, when/doctor?		
Stomach pains	Yes	No
Stomach ulcers	Yes	No
Gastritis	Yes	No
H.pylori infection	Yes	No
Rectal bleeding	Yes	No
Liver disease	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Stomach surgery	Yes	No
Sleep Apnea		
# of hours of sleep per night:		
Diagnosed sleep apnea	Yes	No
If yes, when?		
Actively using oral appliance for mild sleep apnea	Yes	No
CPAP/BIPAP	Yes	No
Frequent waking at night	Yes	No
Choking at night	Yes	No
Aspiration/choking	Yes	No
# of pillows used:		
Cardiovascular		
Swelling of ankles	Yes	No
Chest pain	Yes	No
Have you had an echocardiogram?	Yes	No

Epworth Sleepiness Scale

Please place a check in the appropriate box given each situation ranking your chance of dozing or sleeping	**0**	**1**	**2**	**3**
	Never	**Slight**	**Moderate**	**High**
Sitting and reading				
Watching TV				
Sitting inactive in a public space				
Being a passenger in a motor vehicle for an hour or more				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch (no alcohol)				
Stopped for a few minutes in traffic while driving				
Johns, MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep, 1991; 14:50-55				

Sleep Apnea Questionnaire

Collar size of shirt: Small Medium Large XL or _____ inches/cm

1. Do you snore loudly (louder than talking or to hear through closed door)? 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. Neck circumference greater than 17 inches? Yes No

For Biological Females Only

Gynecological		
Last menstrual period (date):		
Pregnancies	Yes	No
If yes, how many?		
Current menstrual status		
Regular	Yes	No
Irregular	Yes	No
Hysterectomy	Yes	No
If yes, when/why?		
Do you still have your ovaries?	Yes	No
What form of birth control do you use?		

Medications

List all daily medications including over the counter (aspirin, ibuprofen, Aleve, etc.), vitamins, herbs or supplements, and contraceptives.

Please indicate NONE is no medications are taken.

Name	Dosage	Frequency	Reason

Do you take any of the following over-the-counter medications daily?

Aspirin: Yes No NSAIDS: Yes No

Ibuprofen: Yes No Insulin: Yes No

Aleve: Yes No Steroids: Yes No

Allergies

List any known food or medication allergies or sensitivities.

Please indicate NON if no allergies are present

Allergy	Reaction

List any allergies or sensitivities to the following:

Latex: Yes No Reaction: _____

Dye: Yes No Reaction: _____

Iodine: Yes No Reaction: _____

Tape: Yes No Reaction: _____

Food Sensitivities

List any foods that you are sensitive to and the reaction you have.

Food	Reaction

Social History

Religious Preference: _____
Ethnic Background: _____
Education: _____
Number of people living in your home: _____ Who? _____
What type pf work do you do? _____
What type of hobbies or activities do you do? _____

Do you currently smoke? Yes No
Have you ever smoked? Yes No
If yes, age started: _____
age last smoked: _____
average number of cigarettes/day: _____
Do you drink alcohol? Yes No
If yes, number of drinks per week: _____
(drink = 1 shot, 1 glass of wine, 1 beer, or 1 cocktail)
Do you use marijuana? Yes No
If yes, how often: _____
Do you use recreational drugs? Yes No
If yes, what: _____ How often: _____
Do you abuse prescription drugs: Yes No
If yes, what: _____ How often: _____

On a scale of 0-10 how motivated are you to change your lifestyle? _____ (10=highly motivated)

Lifestyle/Weight History

Age you first became overweight: _____ Weight comfortably maintained: _____lbs
Highest adult weight (age 25 and older): _____lbs Lowest adult weight (age 25 and older): _____lbs

Grew Up:		Weight Gain After:		
Select One	Overweight	*Select all that apply*	Moved	Moved
	Normal weight		Marriage	Desk job
	Active in		Divorce	Injury
	Under weight		Separation	Gradual
	Average		Quit smoking	Surgery

On a scale of 1-10 (1=least supportive, 10=very supportive):
How does your spouse/partner feel about your weight issues? _____
How does your family feel about your weight issues? _____
How do your friends feel about your weight issues? _____
Who cooks at home? _____
Do you have financial difficulties with food? _____

Non-Supervised Weight Loss Attempts

Method	Yes	No
None of the below apply		
Health spa		
High protein		

Method	Yes	No
None of the below apply		
Mayo Clinic diet		
Pritkin		

Hypnosis			Richard Simmons		
Low carbohydrate			Scarsdale diet		
Low fat			Stillman diet		
Calorie counting on my own			Sugar Busters		
Gym membership			Slim Fast		
Home gym equipment			South Beach diet		
Atkins diet			Other		

Supervised Weight Loss Attempts

Method	Yes	No	Method	Yes	No
None of the below apply			None of the below apply		
Diet pills from MD			Supervised calorie counting		
Diet shots from MD			Acupuncture		
Overeaters Anonymous			Psychological counseling		
Weight Watchers			Weight loss center		
Health Management Resources			Personal trainer		
T.O.P.S.			Medifast		
Jenny Craig			Metrical		
New Direction			Nutri-System		
Exercise counseling			Optifast		
Nutritional counseling			Other		

Weight Loss Medication

Method	Yes	No	Method	Yes	No
None of the below apply			None of the below apply		
Acutrim			Mazanor		
Adipex-P			Meridia		
Alli			Metabolife		
Amphetamines			Obalan		
Anorex			Orlistat		
Belviq			Phentermine		
Benzphetamine			Phenfen		
Contrave			Plegine		
Dexatrim			Pondimin		
Didrex			Redux		
Fastin			Sanorex		
Fenfluramine			Tenuate		
Qsymia			Wehless		
Herbal Remedies			Xenical		
Ionamin			Other		
Liraglutide/Victoza/Saxenda					

Previous Weight Loss Surgery

Method	Yes	No	Method	Yes	No
Gastric bypass (RNY or other)			Gastric band		
Stomach stapling			Sleeve gastrectomy		

Vertical banded gastroplasty				Other		

Exercise History

Do you regularly exercise? Yes No

If yes, how often and what type: _____

Do you track and/or monitor your activity? Yes No

If yes, what do you use? (Fitbit, pedometer) _____

What barriers do you have to exercise (ex. pain, no access to exercise equipment or gym? _____

_____

Have you exercised regularly in the past? Yes No

If yes, what did you do/when: _____

What stopped you from continuing: _____

Are you able to perform exercises such as walking 3 blocks, swimming or using an exercise bike? Yes No

Average time spent exercising	I don't do this	1x/week	2-3x/week	4-5x/week	6+x/week	Minutes/day
Walking						
Stretching exercise (yoga, Pilates, bands, etc.)						
Weightlifting						
Aerobic						
Other:						

Physical limitations preventing exercise (check all that apply):

Hip Pain:	Yes	No	Back Pain:	Yes	No
Knee Pain:	Yes	No	Fatigue:	Yes	No
Ankle Pain:	Yes	No	Excessive sweating:	Yes	No
Foot Pain:	Yes	No	Shortness of breath:	Yes	No

Nutrition History

Do you track/monitor your calories or food intake?

If yes, what do you use: _____

How often do you track your calories/food intake? _____

How many meals do you eat daily? _____

Do you snack in between meals? Yes No

Are you able to make your own food choices and control your food environment? Yes No

Food Frequency

Estimated servings per day	0-3/day	3-6/day	6-9/day	10+/day
Soda/sugary drinks/sweet tea/lemonade				
Sweets/desserts/candy				
Fried foods/fast food/chips/pizza				
Dairy products/cheese				
Carbs/breads/cereal/pasta				
Fruits/veggies				
Proteins				

Eating Behaviors

	Yes	No		Yes	No
Chaotic eating patterns/not eating regular meal			Preference snacking on:		
Sleepwalking and eating (waking up to see evidence of food consumed with no memory of having eaten it)			Pretzels, chips, starches		
Drinking sweetened beverages-pop, Kool-Aid, etc.			Sweets		
Emotional/stress eating			Large portion sizes		

Other Weight Gain Contributing Factors

	Yes	No		Yes	No
Decrease in activity after job change			Smoking cessation		
Decreased activity after an injury			Weight gain with pregnancy		
Genetics			Yo-yo dieting		
Medications					

Do you currently use or have used any of the following behaviors in the last 6 months to control your weight?

Bingeing and then vomiting
Bingeing followed by food restriction
Vomiting purposefully after eating (bulimia)
Excessive/obsessive calorie restriction/fasting (anorexia)
Excessive/obsessive exercise
Laxative abuse

If any of the above, how long and when? _____

Current Eating:

Do you eat large meals in one sitting? Yes No
If yes, how frequent? _____

Do you frequently skip meals, or only eat 1-2 times per day? Yes No
If yes, how frequent? _____

Do you "graze" or snack frequently throughout the day/evening? Yes No
If yes, how frequent? _____

Do you eat or snack late in the evening or at night? Yes No
If yes, how frequent? _____

PLEASE PROVIDE A LIST OF WHAT YOU HAVE EATEN/HAD TO DRINK IN THE PAST 24 HOURS. LIST ALL FOODS.