SIBLEY MEMORIAL HOSPITAL
JOHNS HOPKINS MEDICINE

☐ Information Session Completed- Date: ____________________
☐ Katherine Lamond, M.D.

# Medical History Questionnaire

## Personal Information

| | |
|---|---|
| Patient Name: ______________________________ | Today's Date: ______________________________ |
| Sex: ☐ Male ☐ Female DOB: _______________ | Social Security No.: ___________________________ |
| Mother's Birth Name: _________________________ | Country of Birth: ______________________________ |
| Street Address: ______________________________ | US Citizen: ☐ Yes ☐ No |
| City State Zip: _______________________________ | Home Phone: ______________________________ |
| Emergency Contact: ___________________________ | Work Phone: _______________________________ |
| Relationship:______________Phone: ___________ | Mobile Phone: ______________________________ |
| Marital Status: _______________________________ | Email: ______________________________________ |
| Ethnicity: ☐ Hispanic or Latino ☐ Unknown | Preferred Communication: ____________________ |
| ☐ Not Hispanic or Latino ☐ Refused | Preferred Language: ☐ English ☐ Other: _________ |
| Race: ☐American Indian or Alaska Native ☐ Asian | Interpreter Needed? ☐ Yes ☐ No |
| ☐ Black or African American ☐Pacific Islander | Religious Preference: _________________________ |
| ☐ White or Caucasian ☐ Other ☐ Unknown | Special Cultural Requests: _____________________ |
| Employer Name: ______________________________ | Do you have an Advance Directive *(Living Will)*? |
| Employment Status: ___________________________ | ☐ No ☐ Yes, please provide copy for your file. |
| What type of work do you do? _________________ | If No, who is your legal representative? |
| ___________________________________________ | Name/Phone: _________________________________ |

## Insurance Information

<u>Primary Insurance</u>

| | | |
|---|---|---|
| Insurance: _________________________ | ID No.: ______________________ | Group: __________________ |
| Policy Holder: ______________________ | DOB: ________________________ | SSN: ___________________ |
| Relationship: _______________________ | Employer Name: _____________ | Ins Phone: ______________ |

<u>Secondary Insurance</u>

| | | |
|---|---|---|
| Insurance: _________________________ | ID No.: ______________________ | Group: __________________ |
| Policy Holder: ______________________ | DOB: ________________________ | SSN: ___________________ |
| Relationship: _______________________ | Employer Name: _____________ | Ins Phone: ______________ |

***Additional Insurance Policy?*** ☐ Yes ☐ No

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| Current Providers | Name | Address | Phone |
|---|---|---|---|
| Primary Care | | | |
| Cardiologist | | | |
| Pulmonologist: | | | |
| Gastroenterologist: | | | |
| Orthopedist: | | | |
| Endocrinologist: | | | |
| Psychiatrist: | | | |
| Psychologist | | | |
| Pharmacy: | | | |

## Weight Loss History

| | |
|---|---|
| Current Weight: _________ Current Height: _________ | How long have you been contemplating weight loss surgery? ________________________ |
| Highest Weight in last 10 years: ________________ | Which procedure are you interested in? __________ |
| Lowest Weight in last 10 years: ________________ | What are your weight loss goals? _______________ |
| Weight, 2 years ago: ________ 1 year ago: _________ | How did you hear about this program? ____________ |
| How many years have you been overweight? _______ | |

## Diet Plan History

Please indicate which diet plans, medication, or other therapies you have attempted in the last 5 years.

| Dates | Programs / Medications | Max Weight Lost | M.D. Supervised |
|---|---|---|---|
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |
| | | | ☐ No ☐ Yes |

## Previous Weight Loss Surgery

☐ No ☐ Yes, year: ____________________________

Laparoscopic or Open? _________________________

Total Weight Loss: ____________________________

Procedure: ___________________________________

Surgeon: _____________________________________

**Please provide a copy of the operative report**

## Allergies

Please list all know medications allergies with reactions (e.g., rash, difficulty breathing, etc.):

Surgical Tape: ☐ Yes ☐ No Latex: ☐ Yes ☐ No Medications: ☐ Yes ☐ No

Other:___________________________________________________________

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## Medications

Attach separate list if needed, include over the counter medications.

| Name | Dosage | Frequency | Indication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Medical History

Do you now, or have you ever had any of the following illnesses or symptoms?

| Condition | Response | Condition | Response |
|---|---|---|---|
| Coronary Artery Disease | ☐ No ☐ Yes, year:___ | Arthritis | ☐ No ☐ Yes, year:___ |
| Congestive Heart Failure | ☐ No ☐ Yes, year:___ | Low Back Pain/Sciatica | ☐ No ☐ Yes, year:___ |
| Hypertension | ☐ No ☐ Yes, year:___ | Migraine Headaches | ☐ No ☐ Yes, year:___ |
| Stroke | ☐ No ☐ Yes, year:___ | Cancer | ☐ No ☐ Yes, year:___ |
| Elevated Cholesterol | ☐ No ☐ Yes, year:___ | GERD/Reflux | ☐ No ☐ Yes, year:___ |
| Elevated Triglycerides | ☐ No ☐ Yes, year:___ | Hepatitis | ☐ No ☐ Yes, year:___ |
| Thyroid Disease | ☐ No ☐ Yes, year:___ | History of Blood Clots | ☐ No ☐ Yes, year:___ |
| Diabetes Mellitus | ☐ No ☐ Yes, year:___ | History of Blood Transfusion | ☐ No ☐ Yes, year:___ |
| Asthma | ☐ No ☐ Yes, year:___ | Deep Venous Thrombosis | ☐ No ☐ Yes, year:___ |
| Shortness of Breath | ☐ No ☐ Yes, year:___ | Menstrual Irregularities | ☐ No ☐ Yes, year:___ |
| COPD | ☐ No ☐ Yes, year:___ | History of Bleeding w/ Surgery | ☐ No ☐ Yes, year:___ |
| Sleep Apnea | ☐ No ☐ Yes, year:___ | Exposure to HIV / AIDS | ☐ No ☐ Yes, year:___ |
| CPAP/BiPAP Machine? | ☐ No ☐ Yes, year:___ | Urinary Incontinence | ☐ No ☐ Yes, year:___ |

- Setting: ____________________

## Other Past Medical History

Please list any other current or past medical conditions for which you have seen a physician or taken medications.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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## Past Surgical History

| | | | |
|---|---|---|---|
| Abdominal Exploration | ☐ No ☐ Yes, year:_____ | Knee Arthroscopy | ☐ No ☐ Yes, year:______ |
| Appendectomy | ☐ No ☐ Yes, year:_____ | Back Surgery/Laminectomy | ☐ No ☐ Yes, year:______ |
| Bowel Resection | ☐ No ☐ Yes, year:_____ | Breast Biopsy | ☐ No ☐ Yes, year:______ |
| Hernia Repair | ☐ No ☐ Yes, year:_____ | Mastectomy | ☐ No ☐ Yes, year:______ |
| Cholecystectomy | ☐ No ☐ Yes, year:_____ | Heart Angioplasty | ☐ No ☐ Yes, year:______ |
| Operation for Reflux | ☐ No ☐ Yes, year:_____ | Heart Catheterization | ☐ No ☐ Yes, year:______ |
| Caesarian Section | ☐ No ☐ Yes, year:_____ | Other Heart Procedure | ☐ No ☐ Yes, year:______ |
| Tubal Ligation | ☐ No ☐ Yes, year:_____ | • Type | ____________________ |
| Hysterectomy | ☐ No ☐ Yes, year:_____ | Cancer Surgery | ☐ No ☐ Yes, year:______ |
| Oophorectomy | ☐ No ☐ Yes, year:_____ | • Type | ____________________ |
| Joint Replacement | ☐ No ☐ Yes, year:_____ | Other: ________________ | ____________________ |
| • Type: | ____________________ | Other:________________ | ____________________ |

## Past Anesthesia History

Please list any difficulty with anesthesia including airway problems.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Family History

Please indicate which family members, if any, have/had the following;

| | **Mother** | **Father** | **Sister** | **Brother** | **Daughter** | **Son** |
|---|---|---|---|---|---|---|
| Obesity | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Anemia | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Bleeding Tendency | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Blood Disorder | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Heart Disease | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Stroke | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| High Cholesterol | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Asthma | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Lung Disease | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Breast Cancer | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Colon Cancer | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Other Cancer | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Arthritis | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Osteoporosis | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Thyroid Disease | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Kidney Disease | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| Psychological Issues | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |

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## Social History

Who will make up your support system? ______________________________

What are your living arrangements? ______________________________

Do you have children living at home? ______________________________

Alcohol Use ☐ No ☐ Yes — Beer/Wine per week: ______________

Shots of liquor per week: ______________

Recreational Drug Use: ☐ No ☐ Yes — Have you ever used intravenous drugs? ☐ No ☐ Yes

Tobacco Use ☐ No ☐ Yes — Packs / Day: ______________

History of Tobacco Use ☐ No ☐ Yes — If yes, when did you quit? ______________

## Gynecological / Obstetric History

Number of pregnancies: ______________

Number of deliveries: ______________

Age of onset of menses: ______________

Age of onset of menopause: ______________

Last normal menstrual period: ______________

Current method of birth control: ______________

## Health Screening History

Date of last mammogram: ______________ Result: ______________

Date of last pap smear: ______________ Result: ______________

Date of last colonoscopy: ______________ Result: ______________

Date of last endoscopy: ______________ Result: ______________

## Mental Health History

Have you ever been treated for depression? ☐ No ☐ Yes, year: __________

Have you ever been hospitalized for mental illness? ☐ No ☐ Yes, year: __________

Are you currently in treatment? ☐ No ☐ Yes, year: __________

Psychiatrist/Psychologist Name & Phone: ______________________________

## Sleep Apnea Risk Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

| Situation | Chance of Dozing<br>***Please indicate 0 through 3*** |
|---|---|
| Sitting and Reading | ______ |
| Watching TV | ______ |
| Sitting inactive in a public place (e.g. Theater or a meeting ) | ______ |
| As a passenger in a car for an hour without a break | ______ |
| Lying down to rest in the afternoon when circumstances permit | ______ |
| Sitting and talking to someone | ______ |
| Sitting quietly after lunch without alcohol | ______ |
| In a car, while stopped for a few minutes in traffic | ______ |
| | ____ **Total** |

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# Review of Systems

Please indicate any of the following that you have experienced either currently or in the past.

## Cardiovascular

- ☐ Abnormal Heart Beats
- ☐ Chest Pain
- ☐ Cold Feet
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pounding
- ☐ High Blood Pressure
- ☐ Loss of Pulses
- ☐ Low Blood Pressure
- ☐ Pain in Arms
- ☐ Pain in Legs
- ☐ Pain in Neck
- ☐ Palpitations
- ☐ Stroke

## Constitutional

- ☐ Abnormal Bleeding
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Tiredness

## Endocrine

- ☐ Adrenal Gland Tumor
- ☐ Diabetes
- ☐ Goiter
- ☐ Hyperthyroid
- ☐ Low Thyroid
- ☐ Previous Radiation
- ☐ Previous Steroid Use
- ☐ Swollen glands
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Vertigo

## Gastrointestinal

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Stool Size
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn / Reflux
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Irritable bowel
- ☐ Jaundice
- ☐ Nausea
- ☐ Pain with Bowel Movement
- ☐ Vomiting

## Genitourinary

- ☐ Abnormal Pap Smear
- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Vaginal Discharge
- ☐ Bladder Infection
- ☐ Blood in urine
- ☐ Frequent Urination
- ☐ Irregular Periods
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Leakage of Urine
- ☐ Loss of Erection
- ☐ Pain with Urination
- ☐ Penile Discharge
- ☐ Trouble starting Urination
- ☐ Vaginal Discharge

## Head and Neck

- ☐ Blurred vision
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Double vision
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Loss of Vision
- ☐ Loss of Smell
- ☐ Lump in Neck
- ☐ Runny Nose
- ☐ Sinus Congestion
- ☐ Sinus Infections
- ☐ Musculoskeletal
- ☐ Abnormal lumps or masses
- ☐ Ankle Pain
- ☐ Arthritis
- ☐ Foot Pain
- ☐ Herniated Disk
- ☐ Hip Pain
- ☐ Joint Pain
- ☐ Knee Pain
- ☐ Low Back Pain
- ☐ Muscular Aches
- ☐ Numbness in feet or legs
- ☐ Sciatica
- ☐ Swelling of Joints

## Neurological

- ☐ Convulsions
- ☐ Fainting
- ☐ Falling
- ☐ Light Headedness
- ☐ Loss of Consciousness
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors

## Psychological

- ☐ Anorexia
- ☐ Anxiety
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Depression
- ☐ Hospitalization for
- ☐ Emotional Problems Nervousness
- ☐ Psychiatric or Psychological counseling
- ☐ Schizophrenia
- ☐ Suicidal Thoughts
- ☐ Suicide Attempts

## Respiratory

- ☐ Asthma
- ☐ Awakening at Night
- ☐ Bloody Sputum
- ☐ Bronchitis
- ☐ Cough
- ☐ Difficulty Sleeping Flat
- ☐ Emphysema
- ☐ Irritability
- ☐ Morning Headaches
- ☐ Observed Apnea Spells Stops Breathing
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Snoring
- ☐ Waking at night short of Breath
- ☐ Wheezing

## Skin/Breast

- ☐ Abnormal Mammogram
- ☐ Abnormal Moles
- ☐ Breast Mass
- ☐ Burns
- ☐ Nipple Discharge
- ☐ Rash
- ☐ Skin Cancer

***Office Use Only***

Reviewed by: ______________________________ Date: ____________________