

NAME:		DOB:	AGE:	
<u>HEALT</u>	H CARE PROVIDERS: Please	list any providers you have seen in the	e past or currently	
1.	Primary PHYSICIAN: ADDRESS: PHONE NUMBER:			
2.	CARDIOLOGIST: ADDRESS: PHONE NUMBER:			
3.	PULMONOLOGIST: ADDRESS: PHONE NUMBER:			
4.	ENDOCRINOLOGIST: ADDRESS: PHONE NUMBER:			
5.	GASTROENTEROLOGIST : ADDRESS: PHONE NUMBER:			
6.	PSYCHIATRIST: ADDRESS: PHONE NUMBER:			
7.	SLEEP MEDICINE: ADDRESS: PHONE NUMBER:			
8.	OTHER PHYSICIAN: ADDRESS: PHONE NUMBER:			

Name:	DOB:		
Prior Weight Loss Attempts	Lowest Adult Weight:	Age:	

Program	Date Month/Year	# of Pounds	# of Pounds Regained	How Long to Regain? Weeks/Months	Physician Supervised Y/N	Dietitian Supervised Y/N
Weight Watchers						
Jenny Craig						
Diet Center						
Atkins						
South Beach						
Nutri-System						
Over-the- counter diet pills						
Prescription diet pills (name)						
Slimfast or similar						
Hypnosis, jaw wiring, acupuncture						
Conventional low calorie						
Other						

Do you currently engage in physical activity?	Yes	No	If yes, describe: _	
What types of exercise programs have you tri	ed in	the pa	ast?	

Name:	DOB:				
HEALTH HISTORY					
Have you had any of the fol	lowing? (Circle those that apply)				
CARDIOPULMONARY	HEMATOLOGY	<u>ENDOCRINE</u>			
Heart attack	Blood clots	Diabetes (insulin dependent)			
Heart catheterization	Pulmonary embolism	Diabetes (non-insulin			
Heart valve prolapse	HIV positive	dependent)			
High blood pressure	Anemia	Thyroid disease			
High cholesterol		Adrenal disease			
Chest pain/Angina	<u>NEUROLOGICAL</u>	Polycystic Ovarian Syndrome			
Pain in arm	Frequent headaches	Growth in neck/throat			
Abnormal heart beat	Fainting spells	Slow wound healing			
Atrial Fibrillation	Dizziness	Skin rash			
Swelling hands/feet	Blurred vision				
Asthma	Pseudotumor Cerebri	<u>GENITOURINARY</u>			
Emphysema/COPD Tuberculosis		Blood in urine			
Frequent cough	MUSCULO-SKELETAL	Lose urine with cough?			
Cough up blood	Recurrent back pain	Kidney stones			
Collapsed lung	Neuritis/neuralgia	Prostate problems			
Night sweats	Joint pain	•			
Wake up with shortness of	Fibromyalgia	VASCULAR			
breath	Redness or heat of joints				
Sleep Apnea (CPAP/BiPAP)	Tingling in hands or feet Muscle spasms	Lymphedema			
Shortness of breath when:	Broken bones	Leg: Right or Left			
Walking several blocks	Ruptured disc	Arm: Right or Left			
One flight of stairs	Neck injury				
On laying down	Arthritis/rheumatism	NUTRITIONAL			
	Paralysis	Depigmentation of skin			
GASTROINTESTINAL	Bipolar	, •			
Acid Reflux	Depression	Easily bruise			
Stomach ulcers	Anxiety	Poor wound healing			
Gallbladder disease	Under care of psychiatrist now	Dental caries			
Hepatitis	or past?	Red swollen gums			
Jaundice	Outpatient/Inpatient counseling	Dry cracked lips			
Crohn's Disease	or treatment for "mental	Dry scaly skin			
Ulcerative Colitis	disorder?"	Dry brittle hair			
Diverticulitis	Treatment for substance abuse,	Thin sparse hair			
Fatty Liver Disease		White spots on nail			
Other:		Winte spots on hair			
Cancer History: Type	; Location	; Date			
Current form of birth control/con	traception in use:	a Injections:			
□ Barrier/Condom method	Last inject	ion date:			
□ IUD Name:		n			
☐ Implant Name:		У			
☐ Oral Contraception Pill:		☐ Other form:			
Medication Name:					

□ Nuva Ring

Nicotine Vape? Y N Use alcoholic beverages? Y N Type Frequency Use "recreational" or "Name Dose Frequency "Street drugs?" Y N Type Frequency Medical Marijuana Card? Y N Chew tobacco? Y N # of years? Gynecological History: #of children: Diagnosis When #of pregnancies: Waginal deliveries: C-Sections: Breast Medical History: Breast Surgery of any type: Y N Breast Lump not operated: Y N Breast cancer: Y N Breast cancer: Y N Last mammogram:	Name:	_ DOB:		_	
Blood transfusion reaction Y N Packs per day? # of years?	Anasthasia reaction V	N	Drug/Modicati	ion Allorgias (Lic+\
Do you smoke cigarettes? Y N Packs per day?			Di ug/ ivieuicati	ion Anergies (<u>LIST)</u>
Packs per day? # of years? Quit date? Do you Vape? Nicotine Vape? V N Nicotine Vape? V N Type Frequency Use "arcreational" or "street drugs?" Y N Type Frequency Medical Marijuana Card? Y N # of years? # of pregnancies: Vaginal deliveries: C-Sections: Breast Medical History: Breast surgery of any type: V N Breast cancer: Do you have any tattoos? Y N Breast cancer: V N Breast Cancer: V N Breast Surgery of any type: V N Breast Cancer: Do you have any tattoos? V N Breast Cancer: Do you have any tattoos? V N Breast Surgery of any type: Correct and list date of surgery if known) Appendectomy Back Back Lung Back Lung Back Back Lung Back Breast Surgery Colon) intestinal surgery Gallbladder Beart Hernia (Hiatal) Hernia (Umbilical) Users, stomach	Dioda transrasion reaction				
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Quit date? Do you Vape? Y N Nicotine Vape? Y N Nicotine Vape? Y N Type					
Quit date? Do you Vape? Y N Nicotine Vape? Y N Nicotine Vape? Y N Type			Food Allergies	(List)	
Nicotine Vape? Y N Use alcoholic beverages? Y N Type			10047013.00	<u> </u>	
Use alcoholic beverages? Y N Type	Do you Vape? Y	N			
Type Frequency Use "recreational" or "street drugs?" Y N Type Frequency Medical Marijuana Card? Y N Chew tobacco? Y N # of years? Gynecological History: # of pregnancies: Vaginal deliveries: C-Sections: Breast Medical History: Breast surgery of any type: Y N Breast lump not operated: Y N Breast lump not operated: Y N Breast lump not operated: Y N Breast yoyou have any tattoos? Y N If yes: Was your tattoo performed in a formal/commercial setting? Y N Surgical History (Circle and list date of surgery if known) Appendectomy Appendectomy Back Back Lung Breast Surgery Colon/ intestinal surgery Gollbladder Hernia (Hiatal) Hernia (Umbillical) Luces, stomach	Nicotine Vape? Y	N			
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Recent Hospitalizations (non-surgical) Gynecological History: #of children:	# of years?				
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Vaginal deliveries: C-Sections: Breast Medical History: Breast surgery of any type: Y N Breast lump not operated: Y N Breast cancer: Y N Last mammogram: Do you have any tattoos? Y N If yes: Was your tattoo performed in a formal/commercial setting? Y N Surgical History (Circle and list date of surgery if known) ———————————————————————————————————	# of pregnancies:	-	Diagnosis		WHEH
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Colon/ intestinal surgery Prostate Gallbladder Thyroid Heart Tonsillectomy Hernia (Hiatal) Tubal ligation Hernia (Umbilical) Ulcers, stomach			-	<u>if known)</u>	
Gallbladder Thyroid Heart Tonsillectomy Hernia (Hiatal) Tubal ligation Hernia (Umbilical) Ulcers, stomach	Appendectomy		-	<i>if known)</i> Knee	
Heart Tonsillectomy Hernia (Hiatal) Tubal ligation Hernia (Umbilical) Ulcers, stomach	Appendectomy Back		-	<i>if known)</i> Knee Lung	
Hernia (Hiatal) Tubal ligation Hernia (Umbilical) Ulcers, stomach	Appendectomy Back Breast Surgery	Circle and list	-	if known) Knee Lung Ovaries	
Hernia (Umbilical) Ulcers, stomach	Appendectomy Back Breast Surgery Colon/ intestinal surge	Circle and list	-	Knee Lung Ovaries Prostate Thyroid	
	Appendectomy Back Breast Surgery Colon/ intestinal surge Gallbladder	Circle and list	-	Knee Lung Ovaries Prostate Thyroid	ny
Hernia (Inguinal) Uterus hysterectomy	Appendectomy Back Breast Surgery Colon/ intestinal surge Gallbladder Heart	Circle and list	-	Knee Lung Ovaries Prostate Thyroid Tonsillecton	•
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Hernia (Ventral) Other	Appendectomy Back Breast Surgery Colon/ intestinal surge Gallbladder Heart Hernia (Hiatal) Hernia (Umbilical)	Circle and list	-	Knee Lung Ovaries Prostate Thyroid Tonsillecton Tubal ligatio	on nach

Name:		DOB:		
		STOP BANG Qu	esti	onnaire
Height	inches/cm	Weightlb	./kg	BMI
Age				
Male/Fema	le			
Neck circui	mference* cr	m (*will be measured	at int	take appointment)
1. Do you	snore loudly (loude	r than talking or loud	enou	igh to be heard through closed doors)?
Yes	No			
2. Do you	often feel tired, fati	gued, or sleepy during	g dayı	time?
Yes	No			
3. Has any	one observed you s	top breathing during y	our s	sleep?
Yes	No			
4. Blood pr	essure Do you have	e or are you being treat	ted fo	or high blood pressure?
Yes	No			
5. BMI mor	re than 35 kg/m2?			
Yes	No			
6. Age over	50 yr. old?			
Yes	No			
7. Neck cir	cumference greater	than 40 cm?		
Yes	No			
8. Gender	male?			
Yes	No			
* Neck circ	cumference is measu	ared by staff		
High risk o	f OSA: answering y	yes to three or more ite	ems	
Low risk of	f OSA: answering y	res to less than three it	ems	

Adapted from: STOP Questionnaire A Tool to Screen Patients for Obstructive Sleep Apnea Frances Chung, F.R.C.P.C.,* Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.# Anesthesiology 2008; 108:812–21 Copyright © 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.

Name:	DOB:

Psychological Screening Questionnaire

Please mark each question in terms of whether you have experienced this behavior in the past or currently (within the last year).

•				
1.	Have you been treated for an emotional disorder (i.e.: depression, anxiety) by a mental health professional or your personal physician?	□No	□ In the Past	□ Currently
2.	Have you been hospitalized for an emotional disorder?	□No	☐ In the Past	□ Currently
3.	Have you had suicidal thoughts on a regular basis or made a suicidal attempt?	□No	☐ In the Past	□ Currently
4.	Have you been treated as an outpatient for an alcohol or substance abuse program or attended a 12-step program such as AA?	□No	□ In the Past	□ Currently
5.	Have you been hospitalized or treated in a residential program for an alcohol or substance abuse problem?	□No	□ In the Past	□ Currently
6.	Have you been treated for an eating disorder such as anorexia, bulimia, or compulsive overeating?	□No	□ In the Past	□ Currently
7.	Have you engaged in binge eating or purging (vomiting) after eating?	□No	☐ In the Past	□ Currently
8.	Have you been placed on disability or lost a job for an emotional or nervous disorder?	□No	☐ In the Past	□ Currently
9.	Have you been separated or divorced?	□No	☐ In the Past	☐ Currently
10	. Have you been in a relationship within or outside the family that you considered abusive?	□No	□ In the Past	□ Currently
11	. Have you been prescribed medication for an emotional or nervous disorder?	□No	☐ In the Past	□ Currently