Northwestern Medicine®

Health Questionnaire

Northwestern Medicine Medical and Surgical Weight Loss Center
Northwestern Medicine Huntley Hospital | 10350 Haligus Road, MOB1 Suite 220, Huntley, Illinois 60142 | 847.802.7230

Information session date_____

Background Information

Name (Last, first, middle initial) _____

Date of birth _____ Gender: ☐ Male ☐ Female ☐ Non-binary

Address _____

City _____ State _____ ZIP _____

Email _____

Home phone _____ May we leave you messages? ☐ Yes ☐ No Available during: ☐ Day ☐ Evening

Cell phone _____ ☐ Yes ☐ No Available during: ☐ Day ☐ Evening

Work phone _____ May we contact you at work? ☐ Yes ☐ No
May we leave you messages? ☐ Yes ☐ No

Employment

Employment status: ☐ Full time ☐ Part time ☐ Self employed ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Occupation_____

Marital status

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Emergency contact_____ Relationship_____

Phone_____ Alternate phone _____

Race (if you are multi-racial, choose all that apply):

☐ Asian ☐ Caucasian/White ☐ Hawaiian or other Pacific Islander ☐ Indian ☐ Declined
☐ Black or African American ☐ Greek ☐ Hispanic or Latino ☐ Native American or Alaska Native ☐ Other:_____

Referring physician

Referring physician _____

Address _____

Phone_____ Fax _____

Primary physician

Primary physician _____

Address _____

Phone_____ Fax _____

Psychiatrist/psychologist

Psychiatrist/psychologist _____

Address _____

Phone_____ Fax _____

Continued >

Health Questionnaire (continued)

Patient Name_____ DOB_____

Insurance

Primary insurance_____

Primary card holder _____ Birthdate _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other:_____

ID number _____ Group number _____

Customer service phone _____

Secondary insurance _____

Primary card holder _____ Birthdate _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other:_____

ID number _____ Group number _____

Customer service phone _____

***Please provide photocopies of front and back of insurance cards.**

What weight loss surgery are you interested in?

☐ Roux-en-Y Gastric Bypass ☐ Gastric Band ☐ Gastric Sleeve ☐ Revision ☐ Unsure

Have you ever had bariatric surgery?

☐ Yes ☐ No

If yes, what surgery and when? _____

Medication and Vitamins/Supplements

☐ **List attached**

Name	Dosage	Time Taken	Reason for Taking

Do you have any allergies to medications?_____

Continued >

Weight Loss History

Height _____. Highest weight as an adult? _____ Date _____

Current weight _____ Lowest weight as an adult? _____ Date _____

BMI _____

Check the appropriate boxes and add notes as needed (please be specific):

My obesity started: ☐ In childhood ☐ At puberty ☐ As an adult ☐ After pregnancy ☐ After a traumatic event

☐ Other: _____

Eating habits (please check all that apply):

☐ Binge eating ☐ Night eating ☐ Grazing/snacking ☐ Emotional eating (☐ Stress ☐ Boredom ☐ Loneliness ☐ Other: _____)

If you have participated in a commercial or professional weight loss program, please provide details below.

Diet Program	Start Date	End Date	Physician Supervised?	Results	Max Weight Loss
Atkins®					
Fen/Phen/Redux/Meridia					
HCG (Releana)					
Jenny Craig®					
Keto					
Nutri System®					
Paleo®					
Phentermine					
Slim Fast®					
Weight Watchers®					
Other:					

Physical Activity

What is the most active thing you do in an average day? _____

What, if any, regular exercise do you participate in and how often? _____

Do you have physical limitations that make increasing activity level difficult? ☐ No ☐ Yes

If yes, explain: _____

Continued >

General Health Questions

When was your last physical exam? _____ When did you last have blood tests? _____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check if you have been diagnosed with any of the following medical conditions at any time:

- ☐ Acid reflux
- ☐ Diabetes
- ☐ Impaired fasting glucose/pre-diabetes
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Heart disease/attack
- ☐ High blood pressure
- ☐ Anesthesia reaction
- ☐ Cancer
- ☐ Liver disease
- ☐ Fatty liver disease
- ☐ Osteoporosis/osteopenia
- ☐ Hepatitis (☐ B or ☐ C)
- ☐ HIV/AIDS
- ☐ Drug/alcohol dependency
- ☐ Irritable bowel syndrome
- ☐ Stomach ulcers
- ☐ Gallbladder disease/stones
- ☐ Hernia (What kind? _____)
- ☐ Stroke
- ☐ Sleep apnea (CPAP use? ☐ Yes ☐ No)
- ☐ COPD
- ☐ Celiac disease
- ☐ Pulmonary embolism
- ☐ Asthma/lung disease
- ☐ Blood clot/DVT
- ☐ Steroid use for chronic condition
- ☐ Congestive heart failure
- ☐ Anemia
- ☐ Migraine/severe headaches
- ☐ Bleeding disorder
- ☐ Arthritis
- ☐ Gout
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder

Please list any additional medical conditions you currently have or may have had in the past that are not mentioned on the above list:

_____

Functional health status: ☐ Independent ☐ Partially dependent ☐ Totally dependent ☐ Unknown

Is your mobility limited? ☐ Yes, all of the time ☐ Yes, some of the time ☐ No

List previous surgeries and hospitalizations.

Procedure/Diagnosis	Date	Hospital

Habits

Do you use tobacco? ☐ Yes (How many years? _____) ☐ Not anymore (Quit date: _____) ☐ Never

Do you drink alcohol? ☐ Yes (How many drinks per week? _____) ☐ No

Do you drink caffeine? ☐ Yes (How many cups per week? _____) ☐ No

Continued >

Family Health History

Relation	Age	Medical Conditions	Overweight or Obese?	Age at Death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Spouse				
Child				
Child				
Child				
Child				

Do you have any spiritual, religious or cultural considerations we need to be aware of?

☐ No ☐ Yes (please describe): _____

On a scale of 1 to 5, with 5 being the most important, how important is it for you to make lifestyle changes? ☐1 ☐2 ☐3 ☐4 ☐5

On a scale of 1 to 5, with 5 being the most confident, how confident are you in your ability to make lifestyle changes? ☐1 ☐2 ☐3 ☐4 ☐5

On a scale of 1 to 5, with 5 being the highest, how would you rate your stress level? ☐1 ☐2 ☐3 ☐4 ☐5

How do you cope with daily stressors?