Dr. Jeremy Joyner ♦ Dr. Sean Sheff
120 Highway 280 West, Suite C
Americus, GA 31719
(229)931-7160

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care and to obtain your insurance approval, we must have complete answers. If you are visually or otherwise impaired and must use an assistant, please indicate his/her name below.

Your name:_____Date of Birth:_____

Person assisting with this form and relationship to you:_____

Date:_____Age:_____Height:_____Weight:_____

Approximately how long have you currently been at least 80-100 pounds overweight?
_____years_____months

Diet History

Approximate age when you first dieted:_____

List the diets and weight loss programs you have tried:

Program	Dates	Duration	MD supervised	Max loss
Jenny Craig				
Nutri-Systems				
Weight Watchers				
OptiFast				
MediFast				
Prescribed Diet Pills i.e. phentermine, fastin, etc				
Metabolife				
Atkins				
Acupuncture				
Other:				

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Name: _____

List any other weight loss attempt(s) your physician supervised and documented: _____
_____

List any others diets and/or weight loss methods you've tried:_____
_____
_____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:_____
_____
_____

Medications: Be sure to list your correct dosages and strengths. Also include any over- the-counter medications, herbal and dietary supplements you take.

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____

Do you take Goody/BC Powders, aspirin, NSAIDs (Motrin, Aleve, etc.) or other aspirin-based products on a regular basis? Yes___ No___. If yes, which ones and how often?
_____

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Name:_____

Medical Conditions/Diseases:
Have you had or do you have any of the following illnesses or conditions? If so, please briefly explain treatment you received:

Heart disease:
Angina Treatment:_____
Heart Attack (MI):When:_____
Coronary artery bypass(CABG):When:_____Hospital:_____
Coronary angioplasty or stents: When:_____Hospital:_____
Abnormal EKG: Treatment:_____
Stress test Abnormal?_____If yes, when and where done?_____
Palpitations/heart murmur/valve problem Treatment:_____
Heart failure, CHF Treatment:_____
Other:_____

Lung/Pulmonary disease:
Asthma_____
COPD (chronic obstructive pulmonary disease)_____
Sleep apnea If yes, CPAP or BiPAP used or recommended?_____
What settings are used?_____mm water
Pneumonia_____After surgery?_____yes_____no
Other_____

Gastrointestinal disease:
Ulcer/bleeding ulcer Treatment:_____
Acid reflux/GERD(gastroesphogeal reflux disease)_____
Irritable bowel syndrome_____
Colitis/diverticulitis_____
Other_____

Kidneys/bladder:
Kidney stones_____
Renal insufficiency/failure (chronic or acute)_____
Urinary retention (particularly after surgery)_____

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Kidneys/bladder continued:
Urinary incontinence (leakage)_____
Other_____

Vascular (blood, blood vessels):
High blood pressure Is it well controlled?_____
High cholesterol_____
High triglycerides_____
Clots in legs (DVT)_____
Clots in lungs (pulmonary embolus)_____
Anemia_____
Free bleeder/hemophiliac_____
Blood transfusion in the past_____
Venous stasis disease/ulcers_____
Other_____

Endocrine:
Diabetes mellitus Year diagnosed_____Oral medication?_____
Insulin injections?_____
Date and value of last hemoglobin A1c:_____
Under-active thyroid_____
Other_____

Nervous System:
Migraine headaches_____
Neuropathy_____
Slipped/degenerative disk_____
Stroke_____
TIAs (mini-strokes)_____
Seizure disorder_____
Other_____

Muscle/Joint/Skeletal disease:
Arthritis_____Where affected_____
Rheumatoid arthritis_____

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Muscle/Joint/Skeletal disease continued:
Lupus (SLE)_____
Gout_____
Spine disease_____
Degenerative joint disease_____
Fractures_____
Fibromyalgia_____
Other_____

Infectious Disease:
Staph infection_____
Hepatitis_____
HIV infection_____
Tuberculosis (TB)_____
Other_____

Mental Health:
Depression_____
Bi-polar_____
Panic disorder_____
Schizophrenia_____
Other_____

Allergies: List any drug allergies or intolerances you know of and the effect(s) they cause:_____

Are you allergic to (circle): tape Latex iodine
Other/food allergies:_____

Surgical History:

Gallbladder removal:_____Open(large incision)?_____Laparoscopic_____
Abdominal:_____
Orthopedic/spinal:_____
Head/neck/throat:_____

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Name:_____

Surgical history continued:
Chest/breast:_____
Pelvic/urinary tract:_____
Plastic surgery:_____
Other surgery not listed above:_____

Did you have any significant complications with any of your operations (infection, bleeding, anesthesia reaction, breathing/lung problems)?_____

Hospitalizations:

Please list any admission(s) and the approximate dates and the reasons(s) other than the surgeries listed above:_____
_____

Family Medical History:

Please list any conditions that tend to run in your family:_____
_____
Did anyone in your immediate family suffer a heart attack before the age of 50?_____

Social history:

Have you ever used tobacco? Yes___No___ What type?_____
When did you quit?_____Approximately how many total years did you use tobacco?_____
Do you use or have you ever used intravenous (IV)drugs?_____
Do you use or have you used illegal drugs?_____
Who resides with you in your household?_____
Do you have any religious objections to medical treatment? Yes___No___If so, what?__
_____
Do you drink any form of alcohol? Yes___No___If so, how many drinks of beer, wine or liquor have you had in the past 7 days?_____Past one month?_____