Danbury Hospital
Western Connecticut Health Network

The Center for Weight Loss Surgery
111 Osborne Street
Danbury, CT, 06810
203.739.7131 / 203.739.1669 fax

Patient Health Questionnaire

Name: _____ DOB: _____ BIV Appt: _____

Please answer the following questions in their entirety. This information will assist us in proving medical necessity to your insurance company for approval of your weight loss surgery.

This form must be completed and returned at your Bariatric Education Class.

Weight Loss History

1. How long have you been overweight? _____ years/months Since what age? _____

2. What are the highest and lowest adult weights: _____lbs. (highest) _____ lbs. (lowest)

3. Have you attempted to lose weight in the past? ☐ NO ☐ YES, if yes, please note on grid below:

Weight Loss Program	Duration	Dates (year)	Total weight loss	Time weight loss was maintained
Weight Watchers ☐ n/a				
Jenny Craig ☐ n/a				
Atkins / Low-carb ☐ n/a				
Medifast / Optifast ☐ n/a				
High Protein Liquid ☐ n/a				
Other: ☐ n/a				

Mental Health:

1. Are you currently receiving any psychological services at this time? ☐ NO ☐ YES
   If yes, please list treating physician: _____
2. Have you been treated in the past for depression/ psychiatric condition? ☐ NO ☐ YES
   If yes, please list treating physician and date(s) of treatment: _____
3. Are you or have you ever been treated for an eating disorder? (Anorexia, bulimia, binge eating, etc.)
   ☐ NO ☐ YES if yes, please describe: _____

Pregnancy History:

**A patient must wait 9 months after giving birth to begin the Program.*

1. Have you ever been pregnant: * ☐ No ☐ Yes
   If yes, date of the most recent birth: _____

Name: _____ DOB: _____

<u>Medical Providers</u>: (Please note any doctor you have seen in the last 3 years)

- ☐ ***Primary Care Physician:*** _____

  Address: _____

  Phone / Fax: _____

- ☐ ***Cardiologist:*** _____

  Address: _____

  Phone / Fax: _____

  Last EKG: Date: _____ n/a: _____

- ☐ ***Gastroenterologist:*** _____

  Address: _____

  Phone / Fax: _____

  Upper Endoscopy: Date: _____ n/a: _____

- ☐ ***Pulmonologist:*** _____

  Address: _____

  Phone / Fax : _____

  Sleep Study: Date: _____ n/a: _____

- ☐ ***Psychiatrist / Mental Health Provider:*** _____

  Address: _____

  Phone / Fax: _____

- ☐ ***Endocrinology:*** _____

  Address: _____

  Phone / Fax: _____

- ☐ ***Other Provider:*** _____

  Address: _____

  Phone / Fax: _____

Name: _____ DOB: _____

Past Medical History: Please check all that apply:

○ **NO PAST MEDICAL HISTORY**	○ COPD	○ IBS (Irritable Bowel Syndrome)
○ Acid Reflux / GERD	○ Coronary Heart Disease	○ Kidney Disease / Dialysis
○ Alcohol abuse / Alcoholism	○ Crohns Disease / Ulcerative Colitis	○ Liver Disease
○ Anemia	○ Depression	○ Menstrual Irregularities
○ Angina	○ Diabetes: type: _____	○ Migraine
○ Anxiety	○ DVT / Blood Clot	○ MI (Heart Attack)
○ Arthritis/Joint Disease	○ IVC Filter: yes no	○ MVA (motor vehicle accident) /
○ Asthma	○ Epilepsy/Seizure	TBI (traumatic Brain Injury)
○ Atrial Fibrillation	○ Gall Bladder disease	○ Neurological disorder: please
○ BPH	○ Heart Murmur	Specify: _____
○ Bleeding Disorder: please	○ Hemophilia / Blood Disorder	○ Osteoarthritis
specify: _____	○ Hepatitis: type: _____	○ Osteoporosis
○ Cancer (Type: _____)	○ HIV / AIDS	○ Peptic Ulcer Disease
○ Cardiac arrhythmias	○ Hyperlipidemia	○ Sleep Apnea
○ Congestive Heart Failure	○ Hypertension	○ Thyroid Disease
○ CVA (stroke)	○ IBD (Inflammatory Bowel Disease)	○ Other: _____

Patient Signature: _____ Date: _____

Name: _____ DOB: _____