



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

Patient Health Questionnaire

Name: _____ DOB: _____

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 the Meet & Greet

Weight Loss History

- How long have you been overweight? _____ years/months Since what age? _____
- What are the highest and lowest adult weights: _____ lbs. (highest) _____ lbs. (lowest)
- 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 <input type="checkbox"/> n/a				
Jenny Craig <input type="checkbox"/> n/a				
Atkins / Low-carb <input type="checkbox"/> n/a				
Medifast / Optifast <input type="checkbox"/> n/a				
High Protein Liquid <input type="checkbox"/> n/a				
Other: <input type="checkbox"/> n/a				

Mental Health:

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

Name: _____ DOB: _____

Smoking History:

Do you smoke? No Yes Former smoker: Quit date: _____

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

Have you ever been pregnant: * No Yes

If yes, date of the most recent birth: _____

Medical Providers: (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: _____

Past Medical History: Please check all that apply:

<ul style="list-style-type: none"> <input type="radio"/> NO PAST MEDICAL HISTORY <input type="radio"/> Acid Reflux / GERD <input type="radio"/> Alcohol abuse / Alcoholism <input type="radio"/> Anemia <input type="radio"/> Angina <input type="radio"/> Anxiety <input type="radio"/> Arthritis/Joint Disease <input type="radio"/> Asthma <input type="radio"/> Atrial Fibrillation <input type="radio"/> BPH <input type="radio"/> Bleeding Disorder: please specify: _____ <input type="radio"/> Cancer (Type: _____) <input type="radio"/> Cardiac arrhythmias <input type="radio"/> Congestive Heart Failure <input type="radio"/> CVA (stroke) 	<ul style="list-style-type: none"> <input type="radio"/> COPD <input type="radio"/> Coronary Heart Disease <input type="radio"/> Crohns Disease / Ulcerative Colitis <input type="radio"/> Depression <input type="radio"/> Diabetes: type: _____ <input type="radio"/> DVT / Blood Clot <ul style="list-style-type: none"> <input type="radio"/> IVC Filter: yes no <input type="radio"/> Epilepsy/Seizure <input type="radio"/> Gall Bladder disease <input type="radio"/> Heart Murmur <input type="radio"/> Hemophilia / Blood Disorder <input type="radio"/> Hepatitis: type: _____ <input type="radio"/> HIV / AIDS <input type="radio"/> Hyperlipidemia/hypercholesterolemia <input type="radio"/> Hypertension <input type="radio"/> IBD (Inflammatory Bowel Disease) 	<ul style="list-style-type: none"> <input type="radio"/> IBS (Irritable Bowel Syndrome) <input type="radio"/> Kidney Disease / Dialysis <input type="radio"/> Liver Disease <input type="radio"/> Menstrual Irregularities <input type="radio"/> Migraine <input type="radio"/> MI (Heart Attack) <input type="radio"/> MVA (motor vehicle accident) / TBI (traumatic Brain Injury) <input type="radio"/> Neurological disorder: please Specify: _____ <input type="radio"/> Osteoarthritis <input type="radio"/> Osteoporosis <input type="radio"/> Peptic Ulcer Disease <input type="radio"/> Sleep Apnea <input type="radio"/> Thyroid Disease <input type="radio"/> Other: _____
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• **What lab do you have your blood drawn?**

- Danbury Hospital
- Quest
- Lab Corp
- Other: _____

Patient Signature: _____ Date: _____

Name: _____ DOB: _____