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: _____

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: _____

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

Primary Care Physician: _____

Address: _____

Phone / Fax: _____

Cardiologist: _____

Address: _____

Phone / Fax: _____

Gastroenterologist: _____

Address: _____

Phone / Fax: _____

Pulmonologist: _____

Address: _____

Phone / Fax : _____

Psychiatrist / Mental Health Provider: _____

Address: _____

Phone / Fax: _____

Other Specialty Provider: _____

Address: _____

Phone / Fax: _____

Nutrition History:

1. Are you currently or have you ever followed a restricted or modified diet? **YES** **NO**
   a. If yes, please describe: _____
2. Do you have any intolerance? **YES** **NO**
   a. If yes, please specify: _____
3. Fluid intake:
   a. How much fluid do you drink daily? _____
   b. Of that total, how much is water? _____
   c. Do you drink fluids during your meal? **YES** **NO**
4. Do you eat quickly? **YES** **NO** if yes, how long is your meal? _____

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: _____

Eating Patterns

1. Do you skip meals? _____ If yes, which ones do you skip and why? _____
   _____
2. How often do you snack? _____
3. How many times per week do you eat out? _____ Usual Choice? _____
4. Do you eat standing up? □ yes □no
5. Do you eat in the car? □ yes □no
6. Do you eat at the table? □ yes □no
7. Do you eat with others? □ yes □no
8. Do you engage in other activities when you eat? □ yes □no
9. Who usually prepares the food at home? _____
10. Do you read food/nutrition labels? □ yes □no
11. Do you travel or entertain for business? □ yes □no
    a. How often? Never Weekly Monthly Occasionally
12. Does your meal and snack pattern vary on the weekend vs. during the week?
    _____
    _____

Food Record Log: Please use the following forms to record your food intake for 2 days

Time / Meal	Food or Drink	Portion / Amount

Patient Signature: _____ Date: _____

Name: _____ DOB: _____