CHI St. Joseph's Health

Essentia Health

Health Screening / Medical History

Personal Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other Contact Source: _____

Age: _____ D.O.B.: ____ /____ / ____ Ht.: _____ Wt.: _____ (If unsure, make best guess.)

Please provide the following for our quality management program.

Ethnicity: Caucasian ____ American Indian ____ African American ____ Asian ____ Hispanic ____

Education: Grade School ____ High School ____ GED ____ College ____ Tech School ____ Post-Grad ____

Occupation/Employer: _____ (Full Time ___)(Part Time ___)

Student ____ Disabled ____ Not Employed ____

Marital Status: Single ____ Married ____ Cohabitating ____ Separated ____ Divorced ____ Widowed ____

Spouse's/Significant Other's Name: _____

Children & Ages: Boys _____ Girls _____

Name of person to contact other than spouse/significant other: _____

Address: _____ Phone #: _____

Physician Information

Family Physician: _____ Phone #: _____

May we contact your family physician? Yes ____ No ____

If you answered "no," may we have the name of a physician in your home town whom we may contact?

Name: _____ Phone #: _____

Address: _____ Phone #: _____

Family History

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Heart Disease								
Cancer								
Arthritis								
High Blood Pressure								

Medical History

Date of last physical:_____Date of last visit to family M.D.:_____

Cardiovascular

Heart problems:	Yes ____ No ____	Comments: _____			
Chest pain:	Yes ____ No ____	Comments: _____			
Racing heart/skipping beats:	Yes ____ No ____	Comments: _____			
High blood pressure:	Yes ____ No ____	Chest tightness:	Yes ____ No ____		
Shortness of breath:	Yes ____ No ____	Shortness of breath when exercising:	Yes ____ No ____		
Elevated cholesterol:	Yes ____ No ____	Elevated triglycerides:	Yes ____ No ____		
Tiredness/fatigue all the time:	Yes ____ No ____	Anemic:	Yes ____ No ____		

Diabetes

Have you been diagnosed with diabetes? Yes ____ No ____ Gestational diabetes? Yes ____ No ____
Your age when diagnosed with diabetes: _____ Most recent A1C: _____
How do you manage your diabetes? Exercise ____ Diet ____ Insulin ____ Medications ____ (Add to medication list on following page.)

Respiratory

Have you ever had asthma? Yes ____ No ____ Have you ever had bronchitis? Yes ____ No ____
Have you ever had pneumonia? Yes ____ No ____ Blood clots in your lungs? Yes ____ No ____
Have you ever been told you stop breathing when you sleep? Yes ____ No ____
Do you snore? Yes ____ No ____ Do you use a CPAP machine? Yes ____ No ____
Do you ever awaken during the night with a smothering feeling? Yes ____ No ____
Do you wake up gasping for breath? Yes ____ No ____
Do you have sleep apnea? Yes ____ No ____

Musculoskeletal

Have you had x-rays to diagnose joint disease? Yes ____ No ____
Have you had x-rays to diagnose degenerative disc disease? Yes ____ No ____
Do you have any joint pain? Yes ____ No ____ Have you been diagnosed with arthritis? Yes ____ No ____
Do you have joint pain in your: Hips ____ Knees ____ Ankles ____ Feet ____
Do you have back pain? Yes ____ No ____ Do you have shoulder or neck pain? Yes ____ No ____
Do you ever experience swelling of the feet, legs, ankles, and/or hands? Yes ____ No ____
Do you have significant varicose veins? Yes ____ No ____
Do the veins in your legs ever get red and/or painful? Yes ____ No ____
Have you ever had a procedure for peripheral vascular disease? Yes ____ No ____
Do you need assistance walking 200 feet? Yes ____ No ____ Cane ____ Walker ____ Wheelchair ____

Gastrointestinal

Have you had problems with your gallbladder? Yes ____ No ____ Has it been removed? Yes ____ No ____
Do you have abdominal pain or gastrointestinal discomfort? Yes ____ No ____
Does your stomach hurt in the middle or on the right side? Yes ____ No ____
Do you have diarrhea? Yes ____ No ____ Do you have vomiting? Yes ____ No ____
Do you experience heartburn? Yes ____ No ____ Do you have kidney disease? Yes ____ No ____

Skin

Have you ever had jaundice? Yes ____ No ____ Have you ever had fungal infections? Yes ____ No ____
Have you had frequent boils, rashes or ringworm? Yes ____ No ____
Have you had skin ulcers or a breakdown of the skin? Yes ____ No ____ Comments: _____

Do you bleed heavily when you cut yourself? Yes ____ No ____

Neuro-Psychiatric

Have you ever been diagnosed with: Depression ____ Anxiety ____ Bipolar ____ Personality Disorder ____
Do you suffer from obesity-related depression? Yes ____ No ____
Have you suffered seizures? Yes ___ No ___ Severe headaches? Yes ___ No ___ Visual problems? Yes ___ No ___
Have you ever been in counseling or advised to seek counseling? Yes ____ No ____

For Females

Have you had problems conceiving? Yes ____ No ____ Date of your last period: _____
Are you periods regular? Yes ____ No ____ Any pain with periods? Yes ____ No ____
Do you experience loss of urine when coughing, sneezing, or laughing? Yes ____ No ____
Do you experience excess nighttime urination? Yes ____ No ____
Do you experience burning or painful urination? Yes ____ No ____
Number or pregnancies: _____ Number of miscarriages: _____
Are you taking birth control pills or any other estrogen/progesterone replacement? Yes ____ No ____
Have you had a tubal ligation? Yes ____ No ____

Prescriptions (include all prescriptions, over the counter, and herbal medications)

Drug Name:	Milligram (mg) Dosage:	How often:
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Are you taking aspirin or ibuprofen for joint or back pain? Yes ____ No ____

Are you allergic to any medication, foods or materials? Yes ____ No ____

If yes, what are they? _____

What's your reaction (e.g., vomiting, rash, etc.)? _____

Substance Use

Do you consume alcohol? Yes ____ No ____ If so, how much and how often? _____

Do you use tobacco? Yes ____ No ____ Are you a former smoker? Yes ____ No ____ Quit date? _____

If you currently use tobacco, how much do you use? _____ When did you start smoking? _____

Do you use any form of street drugs? Yes ____ No ____ If so, what kind and how often? _____

Surgical History

Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.

Dietary History

How many meals do you eat per day? _____

How many snacks and what kind of snacks do you eat each day? _____

How often do you dine out each week? _____ Type of restaurant? _____

What are your favorite foods? _____

Please describe what you eat and when you eat it on a typical day. (Please be specific.) _____

_____

_____

_____

What beverages do you drink on a typical day and how much of each? Milk _____ cups (skim/1%/2%/whole)

Soda _____ ounces Coffee _____ cups Tea _____ cups Fruit Juice _____ cups Water _____ ounces

What are your most difficult struggles with weight management/eating? Grazing ____ Binge Eating ____ Purging ____

Portion Control ____ Night Eating ____ Other _____

When did your obesity begin? _____ At what weight? _____

What was your **highest** weight in the last 12 months? _____ In the last 5 years? _____

What was your **lowest** weight in the last 12 months? _____ In the last 5 years? _____

What is your usual adult weight? _____

Are there any other things about your eating habits you wish to share? _____

_____

Exercise

What kind of exercise/activity are you currently doing? _____

_____

How days per week? _____ For what length of time? _____

Are there any other things about your exercise habits you wish to share? _____

_____

* *

Are there any other questions or concerns we can answer or discuss during your visit? _____

_____

How did you hear about our program? TV station _____ Newspaper _____ Another patient _____ Radio _____

Education group _____ Other _____

Weight Loss Attempts

(It is important to document previous weight loss attempts for insurance purposes.)

Program	Year(s) (e.g., 2009)	# of Months on Program	Weight Lost	How Long Loss Maintained
Dr. Atkins				
Behavior Modification				
Diabetes Education				
Dietitian				
Diet Center				
Exercise Program				
Jaws Wired				
Jenny Craig				
Medi-Fast				
Nutri System				
Nutritionist				
Opti-Fast				
Overeaters Anonymous				
Phen-Fen				
Physician-Directed Diet				
Prescribed Medication				
Psychological Treatment/Therapy				
Richard Simmons				
Slim Fast				
T.O.P.S.				
Weight Watchers				
Self-Monitored Diets				

List doctors or clinics you have visited for weight problems. Include name, address, and types of treatments you have used. Please include all doctors with whom you have discussed your weight.

Prescribing Doctor/Clinic	Address	Treatment Dates	Type (Pills, Shots, Etc.)

Have you had a surgical procedure specifically for obesity or morbid obesity? Yes ____ No ____

If yes, what procedure did you have? _____

Where did you have this procedure, when, and by whom? _____

How much weight did you lose? _____ When did you start to regain weight? _____