Original Date:	**1-1-2015**
Dates Revised:	**1-1-2019**

DR. BARNES NEW PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ **M** ☐ **F**	**DOB:**
Previous or referring doctor:	**Date:**	

PERSONAL HEALTH HISTORY

At what age did you become obese? _____

What was your lowest adult weight? _____

What was your highest adult weight? _____

Current weight: _____ Current height: _____

Do you eat when you are: ☐ Hungry ☐ Depressed ☐ Angry ☐ Sad ☐ Happy

Do you ever intentionally vomit: ☐ Yes ☐ No

Do you binge eat: ☐ Yes ☐ No

What foods are your "weaknesses": _____

Have you ever been treated for or suffered from an eating disorder:

If Yes, please describe treatment, duration, and year: _____

Have you ever had previous weight-loss surgery? ☐ YES ☐ NO

☐ Vertical Banded Gastroplasty Date: _____

☐ Lap Band Date: _____

☐ Roux-en-Y Gastric Bypass Date: _____

☐ Stomach Stapling Date: _____

☐ Malena Band Date: _____

☐ Sleeve Gastrectomy Date: _____

☐ Other not listed: _____ Date: _____

OFFICE USE ONLY

HEIGHT: _____

WEIGHT: _____

BMI: _____

PULSE: _____

O2: _____

BP: _____

LW: _____

List ALL medications you take, both prescription and over-the-counter

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS

Tobacco	Do you use tobacco:	☐ YES ☐ NO
Type: _____	How Often: _____	

Alcohol	Do you drink alcohol:	☐ YES ☐ NO
	How often: _____	

Drugs		☐ YES ☐ NO
Type: _____	Date last used: _____	

WEIGHT LOSS METHODS

Please indicate which of the following weight loss methods you have attempted and the approximate dates:

☐	Redux	☐	Tops	☐	Medifast
☐	NutriSystem	☐	Phen-fen	☐	Jenny Craig
☐	Grapefruit	☐	Optifast	☐	Xenical
☐	Adkins	☐	Slim Fast	☐	Cambridge
☐	Meridia	☐	Sugar Busters	☐	Weight Watchers
☐	Hollywood Diet	☐	Dexatrim	☐	Cabbage Soup
☐	Weight No More	☐	Richard Simmons	☐	Metabolife
☐	Mayo Clinic	☐	Heartsmart	☐	Overeaters Anon

Minimum weight loss on any program: _____

REVIEW OF SYSTEMS

☐	Unexplained weight loss/ weight gain	☐	Swelling feet/ankles	☐	Acid reflux/heartburn
☐	Chest pain/angina	☐	Blood clots in legs/lungs	☐	Pain after eating
☐	Bleeding problems	☐	Change in appetite	☐	Shortness of breath
☐	Vomiting	☐	Seizures	☐	Malaise/Weakness
☐	Constipation	☐	Urinary frequency or hesitancy	☐	Headaches
☐	Numbness/tingling	☐	Diarrhea	☐	Black/tarry stool
☐	Urinary urgency	☐	Weakness	☐	Depression
☐	Calf pain walking	☐	Blood in stool	☐	Nighttime urination
☐	Eating disorder (type) _____	☐	Other _____		

PAST MEDICAL HISTORY

☐	Sleep Apnea	☐	Hepatitis	☐	Infertility
☐	High Blood Pressure	☐	Pancreatitis	☐	Cancer _____
☐	Heart Attack	☐	Gallstones	☐	Transfusions
☐	High Cholesterol	☐	Cirrhosis	☐	Arthritis
☐	Congestive Heart Failure	☐	Yellow Jaundice	☐	Lupus

☐	Pneumonia	☐	Diabetes	☐	Multiple Sclerosis
☐	Asthma	☐	Thyroid Disease	☐	Stroke or Mini Stroke
☐	Emphysema	☐	Enlarged Prostate	☐	Bipolar Disorder
☐	Bronchitis	☐	Frequent Bladder Infections	☐	Schizophrenia
☐	Tuberculosis	☐	Kidney Disease	☐	Reaction to Anesthesia (you or family)
☐	Ulcer Disease	☐	STD	☐	Other Health Problems

PAST SURGICAL HISTORY (*PLEASE GIVE DATE*)					
☐	Exploratory	☐	Cosmetic	☐	Cataracts
☐	Tonsils	☐	Thyroid	☐	Lung resection
☐	Open heart	☐	Stomach	☐	Ulcer
☐	Gallbladder	☐	Appendix	☐	Hernia
☐	Colon	☐	Hemorrhoids	☐	Weight loss surgery
☐	Hysterectomy	☐	Prostate	☐	Vascular
☐	Bone/joint	☐	Tubal ligation	☐	Other surgeries _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS PERFORMED IN THE LAST 2 YEARS (*LIST DATE AND PHYSICIAN*)					
☐	Physical exam	☐	Chest x-ray	☐	Upper GI series
☐	Echocardiogram	☐	EKG	☐	EGD
☐	Colonoscopy	☐	Mammogram	☐	Pap Smear

FAMILY HISTORY (*PLEASE INDICATE RELATION TO YOU AND THEIR AGE WHEN THEY WERE DIAGNOSED*)	
☐	Obesity _____
☐	Cancer (type) _____
☐	Heart disease _____
☐	High blood pressure _____
☐	Diabetes _____
☐	Other _____

PLEASE LIST ALL PHYSICIANS YOU HAVE SEEN IN THE LAST 2 YEARS		
Physician name:	***Specialty:***	***Phone number:***