

MEHTA BARIATRIC CENTER

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New Brunswick, NJ 08901

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MEDICAL QUESTIONNAIRE

First name _____ Last name _____

Address: _____

Home Telephone _____ Work Telephone _____ Cell _____

Social security number _____ E-Mail _____

How you heard about us: _____ Telephone _____

Name and address of referring physician, if any? _____

DOB _____ Age _____ Height _____ Weight _____

Occupation _____

Emergency Contact _____ Telephone _____

Relationship to patient _____

	YES	NO	Uncertain
Diabetes			
High Blood Pressure			
Heart Attack			
Chest Pain (angina)			
Congestive Heart Failure			
Coronary Heart Disease			
Cardiac Arrhythmia			
High Cholesterol			
High Triglycerides			
Hypothyroidism			
Stroke			
Sleep Apnea			
Heel Spurs			
Arthritis			
Shortness of Breath			

Do you have, or have you had, any of the following medical problems?

	Yes	No	Uncertain
Heartburn / Gastro-Esophageal Reflux Disease (GERD)			
Asthma			
Gallstones (Choletithiasis)			
Bladder Incontinence			
Bowel Incontinence			
Varicose veins			
Blood Clots in Legs (DVT)			
Difficulty achieving Pregnancy			
Early Cessation of Periods			
Depression			
Anxiety			
Suicide Attempts			
Psychiatric Disorders			

	Yes	No
Do you snore?		
Do you wake up at night choking or with a feeling of extreme shortness of breath?		
Are you so sleepy during the day that it is hard for you to carry out your activities?		
Has your bed partner/roommate ever told you that you stop breathing while asleep?		

List any other Medical Problems you may have: _____

List all Medications you currently take:

Are you allergic to any medications? _____

List all surgeries you have had. If none, then write none:

Family Medical History:

Obesity	Yes	No
Heart disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No

	Yes	No	How Frequently?
Do you Smoke?			
Do you drink alcohol?			

INSURANCE INFORMATION:

o If you are insured under another person’s coverage, please list that person’s name _____,social security number: _____ and Date of Birth _____

• Primary care physician: name, address, and telephone number: _____

• May we contact the above named physician? Y N

Please list physicians (including name, address, and telephone number) who will provide letters in support of surgical procedure to your insurance company.

Physician	Specialty	Address	Telephone	May we contact him/her?	
				Y	N