

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Street City State Zip Code  
Mailing Address: (If Different) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Street City State Zip Code

Emergency Contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

Membership #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Are you a Beneficiary \_\_\_\_\_ Or Dependent \_\_\_\_\_?

Referring Physician/ Person: \_\_\_\_\_ Tel. # \_\_\_\_\_

I, the undersigned give authorization for release of information contained in the medical record to the insurance companies or other third parties paying my bill in whole or in part and I realize that all medical charges incurred are my financial responsibility, and should the account become delinquent, the entire amount will be due and payable on demand. **I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE ATTENDING PHYSICIAN.**

Signed \_\_\_\_\_ Dated \_\_\_\_\_

H. Joseph Naim, MD, FACS  
 Board Certified Bariatric Surgeon

**PATIENT INTAKE QUESTIONNAIRE**

PATIENT'S NAME: \_\_\_\_\_ Date: \_\_\_\_\_  
 (PLEASE PRINT)

**Please answer the following questions as accurately as possible. The data you provide will assist-us in making an appropriate recommendation for you.**

- Current weight? \_\_\_\_\_ pounds                      Current Height? \_\_\_\_\_
- Maximum weight? \_\_\_\_\_ pounds                      Lowest weight as an adult? \_\_\_\_\_ pounds
- Goal weight? \_\_\_\_\_ pounds
- How many years have you been overweight? \_\_\_\_\_ years
- What is your primary motivation for weight loss, specifically, what would be better about your health or life if you lost weight?

\_\_\_\_\_

\_\_\_\_\_

- Describe your social support system (i.e. spouse, relatives, friends) and their availability.

\_\_\_\_\_

\_\_\_\_\_

- Please complete the following:

<i>Past attempts at weight loss</i>	<i>Years of attempts and months on program</i>	<i>How much weight lost?</i>	<i>How long did you keep the weight off?</i>
Conventional dieting (calorie counting)			
Obesity Treatment Center			
Diet Pills – name: Phen-Phen Meridia Xenical			
Overeater's Anonymous			
Weight Watchers			
Jenny Craig			
Nutri System			
Liquid Fast			
Slim Fast			
Atkins			
Richard Simmons			
B12 Shot			
Metabolite			
Hypnosis			
Acupuncture			
Physician supervised clinic			
Hypnosis			
Other (e.g. Susan Power):			
Other			
Other			
Other			

**FOOD FREQUENCY QUESTIONNAIRE**

Please circle the appropriate boxes. All should reflect your average intake in one day.

<b>FOOD</b>	<b>TYPE/AMOUNT</b>			
<b>MILK/YOGURT</b>	<b>Non-fat</b>	<b>Low-fat</b>	<b>Reduced fat</b>	<b>Whole milk</b>
Amount of Milk and Yogurt	8 oz. (1 cup) or less per day	8-16 oz (1-2 cups) per day	16-24 oz (2-3 cups) per day)	More than 24 oz (More than 3 cups) per day
<b>DESSERTS</b> (Candy, candy bars, chocolate, donuts, etc.)	Less than 1 time per week	1-3 times per week	3-5 times per week	Daily
<b>SNACKS</b> (Potato chips, nacho chips, nuts, etc.)	1-3 times per week	35 times per week	1 per day	2 or more times per day
<b>FRUIT JUICE</b>	8 oz (1 cup) or less per day	8-16 oz (1-2 cups) per day	16-24 oz (2-3 cups) per day	More than 24 oz (More than 3 cups) per day
<b>SWEETENED BEVERAGES</b>	8 oz (1 cup) per day	8-16 oz (1-2 cups) per day	16-24 oz (2-3 cups) per day	More than 24 oz (More than 3 cups) per day
<b>ALCOHOL</b>	Less than 1 drink per day	1-2 drinks per day	More than 2-3 drinks per day	More than 3 drinks per day
<b>FAST FOODS / RESTAURANT MEALS</b>	More than once a week	1-3 times a week	3-5 times per week	Daily

Completed: \_\_\_\_\_ Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**DIRECTIONS:** Please complete this form about yourself. Below is a list of problems and complaints that people sometimes have. Read each one carefully and decide how much discomfort the problem has caused you during the past seven (7) days including today. Circle the number which best describes how much you were distressed. Please answer all the items.

	<b>HOW MUCH WERE YOU DISTRESSED BY:</b>	<b>Not at all</b>	<b>Little Bit</b>	<b>Moderately</b>	<b>Quite a Bit</b>	<b>Extremely</b>	
1.	Nervousness or shakiness inside	0	1	2	3	4	A
2.	Faintness or dizziness	0	1	2	3	4	S
3.	The idea that someone else can control your thoughts	0	1	2	3	4	PS
4.	Feeling others are to blame for most of your troubles						PA
5.	Trouble remembering things	0	1	2	3	4	O
6.	Feeling easily annoyed or irritated						H
7.	Pains in heart or chest	0	1	2	3	4	S
8.	Feeling afraid in open spaces						PH
9.	Thoughts of ending your life	0	1	2	3	4	D
10.	Feeling that most people cannot be trusted						PA
11.	Poor appetite	0	1	2	3	4	
12.	Suddenly scared for no reason						A
13.	Temper outbursts that you could not control	0	1	2	3	4	H
14.	Feeling lonely even when you are with people						PS
15.	Feeling blocked in getting things done	0	1	2	3	4	O
16.	Feeling lonely						D
17.	Feeling blue	0	1	2	3	4	D
18.	Feeling no interest in things						D
19.	Feeling fearful	0	1	2	3	4	A
20.	Your feelings being easily hurt						I
21.	Feeling that people are unfriendly or dislike you	0	1	2	3	4	I
22.	Feeling inferior to others						I
23.	Nausea or upset stomach	0	1	2	3	4	S
24.	Feeling that you are watched or talked about by others						PA
25.	Trouble falling asleep	0	1	2	3	4	

H. Joseph Naim, MD, FACS Board Certified Bariatric Surgeon								
26.	Having to check and double check what you do	0	1	2	3	4		O
27	Difficulty making decisions	0	1	2	3	4		O
28	Feeling afraid of travel on buses, subways, or trains	0	1	2	3	4		PH
29	Trouble getting your breath							S
30	Hot or cold spells	0	1	2	3	4		S
31	Having to avoid certain things, places or activities because they frighten you							PH
32	Your mind going blank	0	1	2	3	4		O
33	Numbers or tingling in parts of your body							S
34	The idea that you should be punished for your sins	0	1	2	3	4		PS
35	Feeling hopeless about the future							D
36	Trouble concentrating	0	1	2	3	4		O
37	Feeling weak in parts of your body							S
38	Feeling tense or keyed up	0	1	2	3	4		A
39	Thoughts of death or dying							
40	Having urges to beat, injure, or harm someone	0	1	2	3	4		H
41	Having urges to break or smash things							H
42	Feeling very self-conscious with others	0	1	2	3	4		I
43	Feeling uneasy in crowds							PH
44	Never feeling close to another person	0	1	2	3	4		PS
45	Spells of terror or panic							A
46	Getting into frequent arguments	0	1	2	3	4		H
47	Feeling nervous when you are left alone							PH
48	Others not giving you proper credit for your achievements	0	1	2	3	4		PA
49	Feeling so restless you couldn't sit still							A
50	Feeling of worthlessness	0	1	2	3	4		D
51	Feeling that people will take advantage of you if you let them							PA
52	Feelings of guilt							
53	The idea that something is wrong with your mind							PS

H. Joseph Naim, MD, FACS  
 Board Certified Bariatric Surgeon

**The Health Score Questionnaire is used to collect information about how you feel about your health. This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.**

1.	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the day	Nearly every day
a	Little interest or pleasure in doing things				
b	Feeling down, depressed, or hopeless				
c	Trouble falling or staying asleep, or sleeping in too much				
d	Feeling tired or having little energy				
e	Poor appetite or overeating				
f	Feeling bad about yourself – or that you are a failure or have let yourself or family down				
g	Trouble concentrating on things, such as reading the newspaper or watching television				
h	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
i	Thoughts that you would be better off dead or of hurting yourself in some way				

2.	Questions about anxiety	NO	YES
a	In the past 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?		
	If you checked “NO”, go to question #4		
b	Has this ever happened before?		
c	Do some of these attacks come suddenly out of the blue – that is, in situations where you don’t expect to be nervous or uncomfortable?		
d	Do these attacks bother you a lot or are you worried about having another attack?		

3.	Think about your last bad anxiety attack	NO	YES
a	Were you short of breath?		
b	Did your heart race, pound, or skip?		
c	Did you have chest pain or pressure?		
d	Did you sweat?		
e	Did you feel as if you were choking?		
f	Did you have hot flashes or chills?		
g	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?		
h	Did you feel dizzy, unsteady, or faint?		
i	Did you have tingling or numbness in parts of your body?		
j	Did you tremble or shake?		
k	Were you afraid of dying?		

H. Joseph Naim, MD, FACS  
 Board Certified Bariatric Surgeon

4.	Over the past 4 weeks, how often have you been bothered by any of the follow problems?	Not at all	Several days	More than half the day	Nearly every day
a	Feeling nervousness, anxious, on edge, or worrying a lot about different things				
	<i>If you checked "not at all", go to question #5.</i>				
b	Feeling restless so that it is hard to sit still				
c	Getting tired very easily				
d	Muscle tension, aches, or soreness				
e	Trouble falling asleep or staying asleep				
f	Trouble concentrating on things, such as reading book or watching TV				
g	Becoming easily annoyed or irritable				

5.	Do you ever drink alcohol (including beer or wine)?	NO	YES
	If you checked "NO", go to question #7.		

6.	Have any of the following happened to you more than once in the last 6 months?	NO	YES
a	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health		
b	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities		
c	You missed or were late for work, school, or other activities because drinking or hung over		
d	You had a problem getting along with other people while you were drinking		
e	You drove a car after having several drinks or after drinking too much		

7.	If you checked off any problems on this questionnaire, how difficult have these problems made it for your work, take care of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely difficult

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

**Patient Medication List**

Name of prescription drugs	Dosage prescribed	Date of Rx
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Name of other medications (nonprescription)	Dosage taken	Date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

List of allergies of any kind including food, medication, and airborne substances.

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

List all surgeries and date

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

**INSTRUCTIONS: Please answer ALL questions by circling ONE number for each question. Do not leave questions blank or circle than one response to each question.**

1. In general, would you say your health is:

*(Please circle ONE number)*

1. *Excellent*
2. *Very Good*
3. *Good*
4. *Fair*
5. *Poor*

2. Compared to I year ago, how would you rate your health now?

*(Please circle ONE number)*

1. *Much Better*
2. *Somewhat Better*
3. *The Same*
4. *Somewhat Worse*
5. *Much Worse*

**The following questions are about activities you might do during a typical day. Does your health now limit you in these activities?**

*(Please circle ONE number on each line)*

	<i>Yes a lot</i>	<i>Yes a little</i>	<i>No, not at all</i>
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	( )	( )	( )
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	( )	( )	( )
5. Lifting or carrying groceries	( )	( )	( )
6. Climbing several flights of stairs	( )	( )	( )
7. Climbing one flight of stairs	( )	( )	( )
8. Bending, Kneeling or Stooping	( )	( )	( )
9. Walking more than a mile	( )	( )	( )
10. Walking several blocks	( )	( )	( )
11. Walking one block	( )	( )	( )
12. Bathing or dressing yourself	( )	( )	( )
	( )	( )	( )

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

The following questions are about how you feel and how things have been with you during the past 4 weeks. For each question check one only that best applies your answer.

	All the Time	Most of the time	Good bit of time	Little of the time	None of the time
1. Did you feel full of prep?	( )	( )	( )	( )	( )
2. Have you been a very nervous person?	( )	( )	( )	( )	( )
3. Have you felt so down in the dumps that nothing could cheer you up?	( )	( )	( )	( )	( )
4. Have you felt calm and peaceful?	( )	( )	( )	( )	( )
5. Did you have a lot of energy?	( )	( )	( )	( )	( )
6. Have you felt down hearted and blue?	( )	( )	( )	( )	( )
7. Did you feel worn out?	( )	( )	( )	( )	( )
8. Have you been a happy person?	( )	( )	( )	( )	( )
9. Did you feel tired?	( )	( )	( )	( )	( )
10. During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities	( )	( )	( )	( )	( )

How true or false is each of the following for you?

	Definitely True	Mostly True	Don't	Mostly	Definitely
11. I seem to get sick a little easier than other people?	( )	( )	( )	( )	( )
12. I am as healthy as anybody I know	( )	( )	( )	( )	( )
13. I expect my health to get worse	( )	( )	( )	( )	( )
14. My health is excellent	( )	( )	( )	( )	( )
15. In past year. Have you had 2 weeks or more during which you felt sad or blue or depressed, or when you lost all interest or pleasure in things that you usually cared about or enjoyed?		Yes ( )		No ( )	
16. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?		Yes ( )		No ( )	
17. Have you felt depressed or sad much of the time in the past year?		( )		( )	

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

18. What is your current combined family income, before taxes?

- Less than \$20,000
- \$20,000 to \$39,999
- \$40,000 to \$59,999
- \$50,000 to \$79,999
- \$80,000 or more

19. What is your current marital status?

- Married
- Widowed
- Separated
- Divorced
- Never Married

20. What is your current education level?

- 8<sup>th</sup> grade or less
- Some high school
- High School Graduate
- Some College
- College Graduate
- Any Post-Grad Education

H. Joseph Naim, MD, FACS  
 Board Certified Bariatric Surgeon

**Medical History:**

**|Mark the problems that you experience.**

<b>Respiratory System</b>	
<input type="checkbox"/> Asthma	ICD-9 code 493.90
<input type="checkbox"/> Daytime sleepiness	ICD-9 code 780.50
<input type="checkbox"/> Fatigue	ICD-9 code 780.79
<input type="checkbox"/> Frequent awakening	ICD-9 code 780.50
<input type="checkbox"/> Hypoventilation syndrome	ICD-9 code 786.09
<input type="checkbox"/> Morning Headaches	ICD-9 code 784.0
<input type="checkbox"/> Night sweats	ICD-9 code 780.8
<input type="checkbox"/> Pickwickian Syndrome	ICD-9 code 278.8
<input type="checkbox"/> Restless sleep	ICD-9 code 780.50
<input type="checkbox"/> Shortness of breath	ICD-9 code 786.05
<input type="checkbox"/> Sleep apnea	ICD-9 code 780.57
<input type="checkbox"/> Snoring	ICD-9 code 786.09
<input type="checkbox"/> Tobacco dependence -Smoking History	ICD-9 code 305.1 - V15.82

<b>Cardiovascular System</b>	
<input type="checkbox"/> Arrhythmia	ICD-9 code 427.9
<input type="checkbox"/> Chest pain	ICD-9 code 786.50
<input type="checkbox"/> Congestive heart failure	ICD-9 code 428.0
<input type="checkbox"/> Heart attack	ICD-9 code 410.9 needs 5 <sup>th</sup> digit 0, 1, 2
<input type="checkbox"/> Heart murmur	ICD-9 code 785.2
<input type="checkbox"/> Hypertension – benign	ICD-9 code 401.1
<input type="checkbox"/> Hypertension – malignant	ICD-9 code 401.0
<input type="checkbox"/> Post-phlebotic syndrome – w/o complic.	ICD-9 code 459.10
<input type="checkbox"/> Varicose veins	ICD-9 code 454.9

<b>Circulatory System</b>	
<input type="checkbox"/> Venous status extremities – lower	ICD-9 code 707.10

<b>Gastrointestinal System</b>	
<input type="checkbox"/> Abdominal pain	ICD-9 code 789.00
<input type="checkbox"/> Diarrhea	ICD-9 code 787.91
<input type="checkbox"/> Hemorrhoids – internal	ICD-9 code 455.0
<input type="checkbox"/> Hemorrhoids – external	ICD-9 code 455.3
<input type="checkbox"/> Hernia – Hiatal	ICD-9 code 553.3
<input type="checkbox"/> Hernia – Incisional	ICD-9 code 553.21
<input type="checkbox"/> Hernia – Ventral	ICD-9 code 553.20
<input type="checkbox"/> Gastroesophageal Reflux Disease (G.E.R.D.)	ICD-9 code 530.81
<input type="checkbox"/> Heartburn	ICD-9 code 787.1
<input type="checkbox"/> Difficulty swallowing	ICD-9 code 787.2
<input type="checkbox"/> Hepatitis – unspecified	ICD-9 code 573.3
<input type="checkbox"/> Nausea	ICD-9 code 787.02
<input type="checkbox"/> Nausea & Vomiting	ICD-9 code 787.01
<input type="checkbox"/> Vomiting	ICD-9 code 787.03
<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Gallstone	

H. Joseph Naim, MD, FACS  
 Board Certified Bariatric Surgeon

<b>Genitourinary System</b>	
<input type="checkbox"/> Blood in urine	ICD-9 code 599.7
<input type="checkbox"/> Frequent urination	ICD-9 code 788.41
<input type="checkbox"/> Kidney stones	ICD-9 code 592.0
<input type="checkbox"/> Painful urination	ICD-9 code 788.1
<input type="checkbox"/> Urinary stress incontinence – Male	ICD-9 code 788.32
<input type="checkbox"/> Urinary stress incontinence - female	ICD-9 code 625.6

<b>Gynecologic problems (Female)</b>	
<input type="checkbox"/> Amenorrhea	ICD-9 code 626.0
<input type="checkbox"/> Heavy periods	ICD-9 code 626.2
<input type="checkbox"/> Irregular periods	ICD-9 code 626.4
<input type="checkbox"/> Painful periods – dysmenorrhea	ICD-9 code 625.3
<input type="checkbox"/> Polycystic ovary disease	ICD-9 code 256.4

<b>Musculoskeletal System</b>	
<input type="checkbox"/> Arthritis – weight bearing joints	ICD-9 code 716.98
<input type="checkbox"/> Degenerative arthritis – Mult. sites	ICD-9 code 715.99
<input type="checkbox"/> Joint pain – Weight bearing joints	ICD-9 code 719.49
<input type="checkbox"/> Joint pain – Back	ICD-9 code 719.48
<input type="checkbox"/> Joint pain – Foot	ICD-9 code 719.47
<input type="checkbox"/> Joint pain – Hip	ICD-9 code 719.45
<input type="checkbox"/> Joint pain – Knee	ICD-9 code 719.46
<input type="checkbox"/> Low back pain	ICD-9 code 724.2
<input type="checkbox"/> Sciatica	ICD-9 code 724.3
<input type="checkbox"/> Swelling of ankles	ICD-9 code 719.07

<b>Skin</b>	
<input type="checkbox"/> Cellulitis – Unspecified site	ICD-9 code 682.9
<input type="checkbox"/> Frequent infections	ICD-9 code 686.9

<b>Emotional System</b>	
<input type="checkbox"/> Anorexia	ICD-9 code 307.1
<input type="checkbox"/> Anxiety	ICD-9 code 300.00
<input type="checkbox"/> Bipolar	ICD-9 code 296.7
<input type="checkbox"/> Bulimia Nervosa	
<input type="checkbox"/> Depression	ICD-9 code 311
<input type="checkbox"/> Depression – manic	ICD-9 code 296.80
<input type="checkbox"/> History of abuse, emotional	ICD-9 code V15.42
<input type="checkbox"/> History of abuse, physical	ICD-9 code V15.41
<input type="checkbox"/> History of alcohol abuse	ICD-9 code V11.3
<input type="checkbox"/> History of drug abuse	ICD-9 code 305.90
<input type="checkbox"/> Panic disorder	ICD-9 code 300.01
<input type="checkbox"/> Stress	ICD-9 code 308.9

<b>Hematological System</b>	
<input type="checkbox"/> Anemia – Secondary to inadequate dietary iron intake	ICD-9 code 280.1
<input type="checkbox"/> Anemia – Pernicious	ICD-9 code 281.0
<input type="checkbox"/> Anemia – Unspecified	ICD-9 code 280.9

H. Joseph Naim, MD, FACS  
Board Certified Bariatric Surgeon

<b>Endocrine System</b>	
<input type="checkbox"/> <b>Diabetes Mellitus type II controlled</b>	ICD-9 code 250.00
<input type="checkbox"/> <b>Diabetes Mellitus type II uncontrolled</b>	ICD-9 code 250.02
<input type="checkbox"/> <b>Glucose Intolerance</b>	ICD-9 code 271.3
<input type="checkbox"/> <b>Hypercholesterolemia</b>	ICD-9 code 272.0
<input type="checkbox"/> <b>Hyperlipidemia</b>	ICD-9 code 272.2
<input type="checkbox"/> <b>Hyperthyroid</b>	ICD-9 code 242.9
<input type="checkbox"/> <b>Hypertriglyceridemia</b>	ICD-9 code 272.1
<input type="checkbox"/> <b>Hypothyroid</b>	ICD-9 code 244.9

<b>Others</b>	
<input type="checkbox"/> <b>Tension Headache</b>	ICD-9 code 307-81
<input type="checkbox"/> <b>Leg Cramps</b>	ICD-9 code 729-82

# Thank You