NORMAN REGIONAL Health System | JOURNEY CLINIC

Name: _____

PATIENT QUESTIONNAIRE

Listed below are 6 medical conditions; please circle the current status of each.			
Diabetes	Never Present	No Improvement	Improved/Solved
Hypertension (High Blood Pressure)	Never Present	No Improvement	Improved/Solved
Sleep Apnea	Never Present	No Improvement	Improved/Solved
Dyslipidemia (High Cholesterol)	Never Present	No Improvement	Improved/Solved
Heartburn/ Reflux/ GERD	Never Present	No Improvement	Improved/Solved
Depression	Never Present	No Improvement	Improved/Solved

Since your last visit with a Doctor, have you been to the ER, had any procedures, or been admitted to a hospital?		
What type of exercise are you doing?		
List all vitamins that you take.		
Do you keep a food journal/log?	( ) Yes	( ) No
Are you measuring your foods?	( ) Yes	( ) No
How many grams of protein do you consume in a day?		
How many meal replacements do you have daily? (Please Circle) What brand?	1 2 3 4	
How many ounces of fluid are you drinking daily?		
Do you drink liquids with meals?	( ) Yes	( ) No
Besides your supplements, do you drink any calorie containing liquids? What kind?	( ) Yes Kind:_____ ( ) No	
How long does it take to eat a meal?	Minute(s)	
How long after eating do you feel hungry?	Hour(s)	
How much food do you eat at a meal?	Cup(s)	Ounce(s)
Does food get stuck?	( ) Yes	( ) No
Do you vomit at least weekly?	( ) Yes	( ) No

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt this eating incident was excessive or out of control?	( ) Yes	( ) No
If you answered yes above how often have you engaged in this behavior in the last year?		
Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?	( ) Yes	( ) No
If you answered yes above how often have you engaged in this behavior in the last year?		

Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?	Never	Sometimes	Always
Do you have trouble controlling your eating when you have positive feelings-do you celebrate feeling good by eating?	Never	Sometimes	Always
When you have unpleasant interactions with others in your life, or a difficult day, do you eat more than you'd like?	Never	Sometimes	Always
Do you think you would benefit from seeing the Psychologist?	( ) Yes		( ) No

Please circle any of the following ulcer triggers that you are using.						
Tobacco	E-Cigarette/Vapor	Steroids	NSAIDS (i.e. ibuprofen)	Caffeine	Carbonation	Alcohol
***Band Patients ONLY:** Do you think you need			A fill	An unfill	Neither	Unsure

Please list all foods and beverages consumed in the past 24 hours:

Breakfast	Snack	Lunch	Snack	Dinner	Drinks

Are there any questions or concerns that you would like to address with the doctor specifically?

_____

_____

_____

_____

_____

_____

_____

_____

I have completed the above information to the best of my knowledge. I understand that this information is important to my provider to help direct care.

Patient Signature_____ Date: _____

(For Internal Use Only:)

Name:_____(DOB ____/____/____) Surgery & Date:_____

IC Weight: _____ (Date:____/____/_____) Last Weight: _____ (Date:____/____/_____) Today's Weight: _____ (Date:____/____/_____) Today's BMI: _____ Today's Waist Cir:_____

Protein Goal:_____ grms AGB Type: _____ Adjustment: **+** / **-** _____ml=_____ml ETV (Date____/____/_____)

Notes:

Reviewed By_____