OFFICE USE ONLY MRN: _____ Consult Date: _____

CentraCare Weight Management

Health History Questionnaire (HHQ)

Name (First-MI-Last)			Birth date (Month-Day-Year)
Street Address	City	State	Zip
Occupation	Name of Employer		
Preferred Phone	Email		

Preferred appointment location □ St. Cloud □ Paynesville □ Monticello

Insurance Information

Primary Insurance	Group Number	ID Number
Insurance Card Provider Phone Number		
Secondary Insurance	Group Number	ID Number
Insurance Card Provider Phone Number		

History

Current Weight (lbs.)	Height (feet, inches)

Have you previously had weight loss surgery? ☐ Yes ☐ No ☐ Unsure
If yes, please describe additional surgery:

Do you currently have Diagnosed Sleep Apnea? ☐ Yes ☐ No **If NO, answer the next three questions:**

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   ☐ Yes ☐ No
2. Do you often feel tired, fatigued, or sleepy during daytime?
   ☐ Yes ☐ No
3. Has anyone observed you stop breathing during your sleep?
   ☐ Yes ☐ No

Medical History

General							
Diabetes Mellitus (Type II)	□ Yes	□ No	□ Unsure	Is ambulation limited most or all the time?	□ Yes	□ No	□ Unsure
Obstructive Sleep Apnea	□ Yes	□ No	□ Unsure	Steroid / Immunosuppressant use for chronic condition	□ Yes	□ No	□ Unsure
High Blood Pressure	□ Yes	□ No	□ Unsure	Therapeutic Anticoagulation	□ Yes	□ No	□ Unsure
High Cholesterol	□ Yes	□ No	□ Unsure	Previous obesity surgery / foregut surgery	□ Yes	□ No	□ Unsure
GERD (heartburn or reflux)	□ Yes	□ No	□ Unsure	History of heart attack (myocardial infarction)	□ Yes	□ No	□ Unsure
Hypothyroidism	□ Yes	□ No	□ Unsure	Previous PCI / PTCA (stents placed in coronary arteries)	□ Yes	□ No	□ Unsure
Polycystic Ovarian Syndrome	□ Yes	□ No	□ Unsure	Vein thrombosis requiring therapy (blood clots)	□ Yes	□ No	□ Unsure
Current smoker within 1 year	□ Yes	□ No	□ Unsure	Venous stasis	□ Yes	□ No	□ Unsure
Functional Health	□ Independent □ Partially dependent □ Totally dependent □ unknown			Currently requiring or on dialysis	□ Yes	□ No	□ Unsure
History of severe COPD	□ Yes	□ No	□ Unsure	Renal insufficiency	□ Yes	□ No	□ Unsure
Oxygen dependent	□ Yes	□ No	□ Unsure	Previous heart (cardiac) surgery	□ Yes	□ No	□ Unsure
History of pulmonary Embolism	□ Yes	□ No	□ Unsure	IVC Filter	□ Yes	□ No	□ Unsure
Males: "How many times in the past year have you had 5 or more drinks in a day?"				**Females**: "How many times in the past year have you had 4 or more drinks in a day?"			
Everyone: How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?							

Please check which program(s) you are interested in

☐ **Surgery**
Consult with Provider and Dietitian. Surgery requirements specific to individual insurance plans must be met along with program requirements.

If Surgery:
Does your insurance cover weight loss surgery? ☐ Yes ☐ No ☐ Unsure

☐ **Medical**
Consult with Provider and Dietitian. Low Calorie or Very Low-Calorie Meal Plan. Labs and insurance utilized. Enrollment fee of **$350** for 24 weeks of personal coaching/provider rotation and unlimited maintenance. Weekly product cost of $84-$112.

☐ **Wellness**
Consult with Dietitian. Low Calorie Meal Plan **ONLY.** No labs or insurance utilized. Enrollment fee of **$350** for 12 weeks of personal coaching rotation and unlimited maintenance. Weekly product cost of $84.

☐ **Customized**
Consult with Provider and Dietitian. Customized plan tailored to you. Labs and insurance utilized. Fees per service.

☐ **ORBERA™**
Consult with surgeon. Surgeon consult billed to insurance. **$8500 CASH PROCEDURE.** After placement, 24 weeks of personal coaching with unlimited maintenance after removal.

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____
Signature Date

To move forward with a visit, please submit this form

Mail
CentraCare Weight Management
Attn: Denell
1200 6th Ave. N
St. Cloud, MN 56303

Email
cchweightmanagement@centracare.com