CentraCare™

Office Use Only **MRN** _____

Health History Questionnaire

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

Preferred appointment location ☐ St. Cloud ☐ Paynesville ☐ Monticello ☐ Willmar ☐ Sauk Centre ☐ Long Prairie

Primary Insurance	Group Number	ID Number
Insurance Card Provider Phone Number		
Secondary Insurance (if applicable)	Group Number	ID Number
Current Weight (lbs)	Height (feet, inches)	

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

Diabetes Mellitus (Type II)	☐ Yes	☐No	☐ Unsure	GERD (heartburn or reflux)	☐ Yes	☐ No	☐ Unsure
Obstructive Sleep Apnea	☐ Yes	☐ No	☐ Unsure	Hypothyroidism	☐ Yes	☐ No	☐ Unsure
High Blood Pressure	☐ Yes	☐ No	☐ Unsure	Polycystic Ovarian Syndrome	☐ Yes	☐ No	☐ Unsure
High Cholesterol	☐ Yes	☐ No	☐ Unsure	Kidney Disease	☐ Yes	☐ No	☐ Unsure
Have you previously had weight loss surgery?	☐ Yes	☐ No	☐ Unsure	**Males**: "How many times in the past year have you had 5 or more drinks in a day?"			
How many times in the past year have you used an illegal drug or prescription medication for non-medical reasons?				**Females**: "How many times in the past year have you had 4 or more drinks in a day?"			

Please check which pathway(s) you are interested in:

☐ **Medical**
Consult with Provider and Dietitian. Program options may include monthly provider visits, wellness coaching, weight loss medications and/or meal replacement products. Prices vary per tailored plan.

☐ **Surgery**
Consult with Provider and Dietitian. Surgery requirements specific to insurance plan and program requirements.

CentraCare Weight Management
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