



SCHNECK MEDICAL CENTER  
*Seymour, Indiana*

**BARIATRIC PATIENT HEALTH QUESTIONNAIRE**

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Today's Date\_\_\_\_\_

Last Name\_\_\_\_\_ First Name\_\_\_\_\_

Sex\_\_\_\_\_ Date of Birth\_\_\_\_\_ Marital Status\_\_\_\_\_

Spouse Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone\_\_\_\_\_ E-mail Address\_\_\_\_\_

Religion\_\_\_\_\_

Employer Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Employer Phone\_\_\_\_\_ (If SMC employee, please put direct phone number)

Occupation\_\_\_\_\_

Emergency Contact\_\_\_\_\_ Relation\_\_\_\_\_

Phone Number\_\_\_\_\_

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Does Patient Have: [ ] Living Will [ ] Durable Power of Attorney

Referring Physician: Last Name\_\_\_\_\_ First Name\_\_\_\_\_