PATIENT HEALTH INFORMATION
WEIGHT LOSS PROGRAM
PERSONAL INFORMATION

Name:_____ Age:_____ Sex:_____ Date of Birth:_____

Address:_____

Home phone:_____ Cell phone:_____ Work phone:_____

Social Security Number: _____ Martial status: _____

Insurance Co and address: _____

Emergency contact name and number: _____

Name and address of Primary Care Physician: _____

_____

PERSONAL HISTORY

HEALTH HABITS

A. Do you currently smoke? □Yes □ No If yes, how may a day?_____ Cigars or chewing tobacco?_____

B. If you used tobacco products in the past, when did you quit? _____

C. Eat sweets frequently □Yes □ No If yes, how much a day? _____

D. Do you drink alcohol? □ Yes □ No How much/how often? _____/_____

E. Do you know or have you ever used illegal drugs? □ Yes □ No Explain _____

F. Do you wear any of the following? □ Ortho braces □ Special shoes □ Hearing aid(s) □ Glasses □ Dentures □ CPAP/Bipap □ Other(specify) _____

G. Do you exercise? □ Yes □ No If yes, what type of exercise and how often?_____

H. What is your occupation? _____ Do you lift heavy objects in your job? □ Yes □ No

I. Do you have any history of eating disorders (anorexia, bulimia, etc.)?_____ Please explain._____
_____

HEALTH HISTORY

I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important the physician has complete and accurate information in order to provide safe medical evaluation and care. I understand that this medical history may be used in providing care through the Bariatric Center and that some information may be needed to share with referring physicians/counselors.

_____ _____

Signature Date

ALLERGIES

Do you have any allergies to Drugs, Environmental Agents, Food Agents or Latex?

□ No known allergies □Yes, if yes, describe Allergy - Describe Reaction

_____
_____
_____
_____

MEDICATIONS

Please list all medications you are currently taking or have taken in the last 30 days (including vitamins, birth control pills, herbal medications, etc.) Include actual dosage and frequency.

MEDICATION	*DOSE*	*FREQUENCY*

HOSPITALIZATIONS and SURGERIES

TYPE/REASON	SURGEON	PLACE OF SURGERY	DATE(if known)

Previous weight loss surgery? Yes_____ No_____

TYPE	SURGEON	DATE	RESULTS

ILLNESS HISTORY

ILLNESS-Check YES or No; if you have currently or have ever had the following conditions/illnesses.

1.	Serious infection, tumors/cancer □Yes □No	**29**.Ulcers	□Yes □No
2.	Skin problems/rashes □Yes □No	**30**. Liver or Gallbladder problems	□Yes □No
3.	Sinus problems □Yes □No	**31**. Bowel irregularities	□Yes □No
4.	Hay fever □Yes □No	**32**. Abdominal Pain	□Yes □No
5.	Ear infections □Yes □No	**33**. Frequent heartburn	□Yes □No
6.	Eye problems □Yes □No	**34**. Frequent vomiting/nausea	□Yes □No
7.	Hoarseness □Yes □No	**35**.Bloody stool/urine	□Yes □No
8.	Asthma/wheezing □Yes □No	**36**. Kidney Stone	□Yes □No
9.	Emphysema □Yes □No	**37**. Frequent urination	□Yes □No
10.	Pneumonia/Bronchitis □Yes □No	**38**. Bladder control/incontinence	□Yes □No
11.	Cannot breath lying flat □Yes □No	**39**. Painful urination	□Yes □No
12.	Shortness of breath □Yes □No	**40.** Bone/joint problems	□Yes □No
13.	Frequent coughs/colds □Yes □No	**41**. Back/neck pain	□Yes □No
14.	Coughing up blood/mucus □Yes □No	**42**. Arthritis/Gout	□Yes □No
15.	Soaking night sweats □Yes □No	**43**. Knee/Hip surgery	□Yes □No
16.	Heart valve problems □Yes □No	**44**. Numbness/tingling in hands or feet	□Yes □No
17.	Chest pain □Yes □No	**45**. Dizziness	□Yes □No
18.	Heart attack □Yes □No	**46**. Stroke	□Yes □No
19.	High blood pressure □Yes □No	**47**. Headache	□Yes □No
20.	High cholesterol □Yes □No	**48**. Sleep Apnea	□Yes □No
21.	Heart murmur □Yes □No	**49**. Diabetes	□Yes □No
22.	Varicose veins □Yes □No	**50**. Thyroid Problems	□Yes □No
23.	Blood clots □Yes □No	**51**. Tiredness/Fatigue	□Yes □No
24.	Bleeding problems/anemia □Yes □No	**52**. Depression or emotional problems	□Yes □No
25.	Ever receive blood transfusion □Yes □No	**53.** Anxiety/ Stress	□Yes □No
26.	Palpitation/irregular heart rate □Yes □No	**54**. Other	□Yes □No
27.	Pacemaker □Yes □No	_____	
28.	Edema/Swelling □Yes □No	_____	

Please explain any check from above starting with the number, please identify if this is a current or past problem.

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FAMILY HISTORY

Check Correct Box	Father	Mother	Brothers	Sisters	Father's Father	Father's Mother	Mother's Father	Mother's Mother
Asthma								
Heart Attack								
Cancer								
Diabetes								
Gallbladder Disease								
High blood pressure								
Strokes								
Weight Problems								
Arthritis/Gout								
Seizure								
Problems with Anesthesia								

SLEEP SCREENING

	QUESTION	YES	NO
2	Do you snore?		
2	If you snore, do others say your snoring is interrupted by choking or snoring sounds?		
2	Do others say you stop breathing while you sleep?		
2	Do you have trouble staying awake when you want to be awake?		
2	Do you fall asleep during any of the following? A. Watching TV: __ Never __ Rarely __ Sometimes __Frequently B. While at work: __ Never __ Rarely __ Sometimes __Frequently C. At the movies, church __ Never __ Rarely __ Sometimes __Frequently		
1	Do you fall asleep frequently while reading books or newspapers?		
2	Have you ever fallen asleep while driving?		
1	Do you have trouble getting to sleep or staying asleep when you want to sleep?		
1	Do you feel tired after 8 hours of sleep?		
1	Do you frequently get less than 7 hours of sleep in 24 hours?		
1	Do you have restless or crawling feelings in your legs when you sit or lie down?		
1	Do others say you have jerking movements of your legs during your sleep?		
	Total		

5 or less= **LOW** 5-8= **MODERATE** Above 8= **HIGH RISK**

How much caffeine do you have a day?
Coffee_____ Soft drinks_____ Tea _____ Chocolate_____ Other_____
Do you have any other sleep related problems? _____ Yes _____ No
Have you had a sleep study in the last 2 years? _____Yes _____ No Use CPAP/Bipap __ Yes __No
If yes,
explain:_____

WEIGHT LOSS HISTORY

Please spend time completing this questionnaire in as complete detail as possible. This information is extremely important in determining your appropriateness for weight loss surgery.

Ideal weight _____ Age weight was first problem_____ Highest weight _____
Age at first weight loss attempt _____ Obese as a child _____Yes _____No
Birth weight _____

Check all boxed that apply to you

□Medi-Fast	□Opti-Fast	□Jenny Craig	□Richard Simmons	□Weight Watcher
□Nurti-Systems	□Gloria Marshall	□Pritikin	□T.O.P.S.	□Scarsdale
□Herbal Life	□Susan Powter	□Sweet Success	□Ca; Bam 3000	□Accutrim
□Slim fast	□Beverly Hills	□Physician's Weight Loss Center		□Dieter's Tea
□Atkins	□Cal Slim	□Diurex	□Amphetamines	□Fen-Phen
□Hypnosis	□Thyroid Supplements	□Fat Burner	□Cambridge	□Cabbage Soup
□Stillman	□Dexatrim	□Gastric Bubble	□Acupuncture	□Jaw Wiring

Injections: □B-6 □B-12 □HCG □Urine □Other

Give complete details of all boxes checked above. (Start with most recent)
Please try to give as much specific information as possible.

Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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Name of Method_____ Date Tried_____ To_____

Weight Lost_____ Weight Gained_____ Results_____

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