

**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. Are there any barriers that prevent you from exercising or walking after surgery?  
\_\_\_\_\_
- I. What is your occupation? \_\_\_\_\_ Do you lift heavy objects in your job?  Yes  No
- J. 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.

<i>MEDICATION</i>	<i>DOSE</i>	<i>FREQUENCY</i>

**HOSPITALIZATIONS and SURGERIES**

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

Previous weight loss surgery? Yes      No

<b>TYPE</b>	<b>SURGEON</b>	<b>DATE</b>	<b>RESULTS</b>



**FAMILY HISTORY**

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

**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

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

Injections: B-6 B-12 HCG Urine Other

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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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