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PATIENT WEIGHT LOSS AND MEDICAL HISTORY QUESTIONAIRE

The following information is very important to your health. Please take time to ***fully and completely fill out*** this important information.

Name: _____

Weight: _____ Height: _____ Date of Birth: _____Age: _____

Primary care physician_____ Phone #:_____

MEDICATIONS: List all medications you are currently taking.

NAME	DOSAGE	FREQUENCY	INDICATION

Allergies to medications: _____

PAST SURGICAL HISTORY: **List all surgical procedures or operations.**

PROCEDURE	DATE	HOSPITAL	INDICATIONS

FAMILY HISTORY: Indicate family members having any of the following illness.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Cancer								
Seizures								
Arthritis								
Stroke								
High Blood Pressure								
Heart Disease								
Breathing Problems								
Kidney Disease								
Early Death & cause								
Other not listed above								

How many years have you been over weight? _____

PREVIOUS WEIGHT LOSS SURGERY: NO _____ YES _____ please indicate below.

SURGERY TYPE	DATE	SURGEON	WEIGHT LOSS

DIET PROGRAMS AND SUPPLEMENTS: Indicate which of the following diets/plans you have attempted?

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutri/System				
Atkins Diet				
Herbalife				
Slim Fast				
Grapefruit Diet				
Liquid Diets				
Pritikin Diet				
Optifast				
TOPS				
Other				

WEIGHT LOSS MEDICATION HISTORY: Indicate if you have taken any of the following medications to lose weight?

MEDICATION	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexfenfluramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication				

Have you participated in a structured dietary program overseen by one of the following? Check any that may apply:

- ❑ Physician (MD or DO)
- ❑ Registered dietician (RD)
- ❑ Board certified specialist in pediatric nutrition (CSP)
- ❑ Board certified specialist in renal nutrition (CSR)
- ❑ Fellow of the American Dietetic Association (FADA)

NON DIETARY THERAPIES: Indicate if you have tried any of the following weight loss therapies?

THERAPY	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

SOCIAL HISTORY:

Do you use tobacco? Yes No

Number of packs per day: _____

Years of tobacco use: _____

When did you stop smoking: _____

Never used tobacco: Yes No

Do you use alcohol? Yes No

Amount and frequency: _____

SYSTEM REVIEW Check all that apply:

Constitutional:
- ❑ Fatigue
- ❑ Tiredness
- ❑ Recent Weight Loss
- ❑ Fever
- ❑ Night Sweats
- ❑ Abnormal Bleeding
- ❑ Anemia

Head and Neck:
- ❑ Blurred vision
- ❑ Double Vision
- ❑ Loss of Vision
- ❑ Loss of hearing
- ❑ Vertigo/Sinus Congestion
- ❑ Runny nose
- ❑ Sneezing
- ❑ Loss of smell
- ❑ Sinus infection
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Lump in neck
- ❑ Pain swallowing

Cardiovascular:
- ❑ Chest Pain
- ❑ Pain in arm/neck
- ❑ Heart Attack
- ❑ Palpitations
- ❑ Heart pounding
- ❑ Heart murmur
- ❑ Pain in legs
- ❑ Cold feet
- ❑ Loss of pulses
- ❑ Low blood pressure
- ❑ High Blood pressure
- ❑ Abnormal heart beats

Respiratory:
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Wheezing
- ❑ Cough
- ❑ Bloody sputum
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Difficulty sleeping flat
- ❑ Waking at night short of breath

Gastrointestinal:
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Cirrhosis
- ❑ Vomiting
- ❑ Nausea
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Pain with bowel movements
- ❑ Blood in stool
- ❑ Hemorrhoids
- ❑ Change in stool size
- ❑ Irritable bowel
- ❑ Colitis

Genitourinary:
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Leakage of urination
- ❑ Pain with urination
- ❑ Trouble starting urine
- ❑ Kidney stones
- ❑ Bladder infection

Men:
- ❑ Discharge from penis
- ❑ Loss of erection

Women:
- ❑ Vaginal Discharge
- ❑ Abnormal vaginal bleeding
- ❑ Irregular periods
- ❑ Hysterectomy
- ❑ Pap exam within last year

Musculoskeletal:
- ❑ Pain in joints
- ❑ Muscular aches
- ❑ Swelling of joints
- ❑ Arthritis
- ❑ Pain in hips
- ❑ Pain in knees
- ❑ Pain in ankles
- ❑ Pain in feet
- ❑ Low back pain
- ❑ Herniated disk
- ❑ Sciatica
- ❑ Numbness in feet / legs
- ❑ Abnormal lumps or masses

Endocrine:
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Goiter
- ❑ Previous radiation
- ❑ Diabetes
- ❑ Adrenal gland tumor
- ❑ Previous steroid use
- ❑ Swollen glands

Skin/Breast:
- ❑ Skin Cancer
- ❑ Abnormal Moles
- ❑ Burns
- ❑ Rash
- ❑ Breast mass
- ❑ Nipple discharge
- ❑ Mammogram within last year
- ❑ MRSA

Neurological:
- ❑ Seizures
- ❑ Convulsions
- ❑ Fainting
- ❑ Vertigo
- ❑ Light headedness
- ❑ Falling
- ❑ Muscle weakness
- ❑ Numbness
- ❑ Tremors
- ❑ Stroke
- ❑ Loss of consciousness

Psychological:
- ❑Depression
- ❑ Nervousness
- ❑ Anxiety
- ❑ Suicidal thoughts
- ❑ Suicide attempts
- ❑ Schizophrenia
- ❑ Anorexia
- ❑ Bulimia
- ❑ Binge eating
- ❑ Counseling
- ❑ Hospitalization for emotional problems
- ❑ Bipolar Disorder

Have you ever been diagnosed with one of the following psychological/psychiatric conditions? Check if one applies:

- ❑Schizophrenia, borderline personality disorder, suicidal ideation, severe or recurrent depression, or bipolar affective disorders with difficult-to-control manifestations (e.g., history of recurrent lapses in control or recurrent failure to comply with management regimen).
- ❑Mental retardation that prevents personally provided informed consent or the ability to understand and comply with a reasonable pre-and postoperative regimen.
- ❑Any other psychological/psychiatric disorder that, in the opinion of a psychologist/psychiatrist, imparts a significant risk of psychological/psychiatric decompensation or interference with the long-term postoperative management.

Have you ever been treated for depression? Yes No
Are you currently in treatment? Yes No
If yes, please indicate the name of your physician or therapist:
_____
Have you ever been hospitalized for mental illness? Yes No

OBESITY REALTED MEDICAL HISTORY:

Do you have or have you had any of the following illness or symptoms?

Heart disease	Yes	No	Year of diagnosis _____
Angina	Yes	No	Year of diagnosis _____
MI (Heart attack)	Yes	No	Year of diagnosis _____
Coronary bypass surgery	Yes	No	Year of surgery _____
Palpitations (abnormal heart beat)	Yes	No	Year of diagnosis _____
Congestive heart failure	Yes	No	Year of diagnosis _____
High blood pressure	Yes	No	Year of diagnosis _____
Elevated cholesterol	Yes	No	Year of diagnosis _____
Elevated triglycerides	Yes	No	Year of diagnosis _____
Asthma	Yes	No	Year of diagnosis _____
Reflux	Yes	No	Year of diagnosis _____
Heartburn	Yes	No	Year of diagnosis _____
Esophagitis	Yes	No	Year of diagnosis _____
Hiatel Hernia	Yes	No	Year of diagnosis _____
Sleep Apnea	Yes	No	Year of diagnosis _____
Do you use CPAP/BiPAP	Yes	No	
Shortness of breath	Yes	No	
Can you walk _____ block			
Climb _____ flight of stairs			
Sleep difficulties:			
Snoring	Yes	No	
Awakening at night	Yes	No	
Daytime drowsiness	Yes	No	
Observed apnea spells	Yes	No	
Leg or ankle edema (swelling)	Yes	No	
Venous Stasis	Yes	No	
Leg ulceration	Yes	No	
Morning headaches	Yes	No	

Pain of Arthritis	Yes	No	
In ankles	Yes	No	
In knees	Yes	No	
In hips	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	
Low back pain/Sciatica	Yes	No	
Limits ability to walk	Yes	No	
Limits ability to exercise	Yes	No	
Diabetes	Yes	No	Year of diagnosis _____
Juvenile onset			
Gestational (pregnancy)			
Adult onset			
Diet controlled	Yes	No	
Oral medications	Yes	No	
Insulin	Yes	No	
Urinary Incontinence	Yes	No	
Leaking urine with cough	Yes	No	
Leaking urine with sneezing	Yes	No	
Leaking urine with straining	Yes	No	
Migraine	Yes	No	
Frequency _____			
Deep Venous Thrombosis	Yes	No	Year of diagnosis _____
Pulmonary embolism	Yes	No	
Abdominal wall hernia	Yes	No	
Incisional	Yes	No	
Umbilical	Yes	No	
Number of hernia repairs _____			
Have you ever had:			
Blood transfusion	Yes	No	
Hepatitis	Yes	No	
Exposed to HIV/AIDS	Yes	No	
Abused intravenous drugs	Yes	No	

PAST MEDICAL HISTORY

Please list all other medical conditions, illness or important information not previously mentioned:

_____

_____

_____

Patient signature: _____ Date: _____

The above is true, correct and complete to the best of my belief