PATIENT INFORMATION (please print)

NAME _____
ADDRESS _____
_____
_____
_____
PHONE _____
Cell Phone _____
E-MAIL _____

DATE OF BIRTH _____
OCCUPATION _____
MARITAL STATUS _____

SOCIAL SECURITY # _____
DRIVER'S LICENSE # _____

EMPLOYER _____
BUSINESS ADDRESS _____
_____
_____
BUSINESS PHONE _____

INSURANCE CO. _____
ID # _____
POLICY # _____
GROUP # _____

SPOUSE OR PARENT INFORMATION

NAME _____
ADDRESS _____
_____
_____
_____
PHONE _____
E-MAIL _____

DATE OF BIRTH _____
OCCUPATION _____
MARITAL STATUS _____

SOCIAL SECURITY # _____
DRIVER'S LICENSE # _____

EMPLOYER _____
BUSINESS ADDRESS _____
_____
_____
BUSINESS PHONE _____

INSURANCE CO. _____
ID # _____
POLICY # _____
GROUP # _____

DO YOU HAVE MEDICARE COVERAGE? _____

PRIMARY PHYSICIAN_____PHONE_____
REFERRING PHYSICIAN_____PHONE_____

HOW DID YOU HEAR ABOUT US?_____

EMERGENCY CONTACT *(relative, friend or neighbor)*
NAME_____ RELATIONSHIP_____
ADDRESS_____ PHONE _____

COMMERCIAL INSURANCE:
I hereby authorize payment of benefits directly to the attending physician. I hereby authorize the attending physician to release any information acquired in the course of my examination and treatment to permit processing of claims for insurance reimbursement.
A photocopy of this signature is valid as the original.

SIGNATURE OF PATIENT OR REPRESENTATIVE_____
PLEASE PRINT YOUR NAME_____ DATE_____

NAME_____ TODAY'S DATE_____

HEALTH HISTORY QUESTIONNAIRE

DATE OF BIRTH _____ AGE _____ WEIGHT _____
PLACE OF BIRTH _____ HEIGHT _____

PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN	
NAME	_____	NAME	_____
ADDRESS	_____	ADDRESS	_____
	_____		_____
	_____		_____
PHONE	_____	PHONE	_____
FAX	_____	FAX	_____

WEIGHT LOSS HISTORY

At what age did you become obese? _____
What was your lowest adult weight? _____
What was your highest adult weight? _____
What is your desired or goal weight? _____

Please describe your age and situation (major stress, if any) at the onset of your obesity:

_____

_____

_____

_____

Approximate weight:
20 yrs. ago _____ 10 yrs. ago _____ 5 yrs. ago _____ 2 yrs. ago _____
1 yr. ago _____ 6 mos. ago _____

WEIGHT LOSS PROGRAMS/DIETS/MEDICATIONS
Maximum weight lost on **any** program: _____

☐	Weight Watchers	☐	Jenny Craig	☐	Atkins Diet
☐	Slimfast	☐	Nutrasystems	☐	Weight Mgt. Prog.
☐	Optifast	☐	Medifast	☐	Cambridge
☐	Metabolife	☐	Diet Center	☐	Meridia
☐	Phen-Fen	☐	Xenical	☐	Redux

☐ Other physician/hospital supervised programs: _____

NAME _____

MEDICAL HISTORY *(Please check yes or no)*

YES	NO		
☐	☐	Have you had a recent Physical Exam?	If yes, date of exam: _____
☐	☐	Have you had a recent Chest X-ray?	If yes, date of X-ray: _____
☐	☐	Have you had a recentEKG?	If yes, date of X-ray: _____
☐	☐	Have you had a recent Abdominal X-Ray?	If yes, date of EKG: _____
☐	☐	Have you had a recent CT Scan/MRIs?	If yes, date of test: _____
☐	☐	Have you had a recent endosopy/colonoscopy?	If yes, date of EKG: _____
☐	☐	Have you had recent blood and urine tests?	If yes, date of test: _____

ALLERGIES: REACTION

_____

_____

Have you had any of the following *obesity-related* conditions?

YES	NO	
☐	☐	Asthma – Worsening with weight
☐	☐	Belching of sour fluid
☐	☐	Bulimia/excessive vomiting
☐	☐	Coughing or choking at night
☐	☐	Daily headaches
☐	☐	Daytime falling asleep
☐	☐	Depression (severe)
☐	☐	Diabetes Mellitus
☐	☐	Gallbladder disease
☐	☐	Gout
☐	☐	Abdominal/Inguinal Hernia
☐	☐	Heartburn/Esophagitis
☐	☐	Hiatal Hernia
☐	☐	High Cholesterol
☐	☐	High blood pressure
☐	☐	Leakage of urine
☐	☐	Pain/Arthritis in lower back
☐	☐	Pain/Arthritis in hips
☐	☐	Pain/Arthritis in knees
☐	☐	Pain/Arthritis in ankles/feet
☐	☐	Shortness of breath
☐	☐	Rash/Dermatitis
☐	☐	Sleep apnea Syndrome
☐	☐	Swollen ankles/feet
☐	☐	Varicose veins

Please indicate if you had any of the Following conditions *at any time*:

YES	NO	
☐	☐	Anemia
☐	☐	Angina
☐	☐	Asthma – Allergy/Childhood
☐	☐	Autoimmune Disease
☐	☐	Bladder/kidney infections
☐	☐	Blood transfusions
☐	☐	Blood Clots
☐	☐	Cancer
☐	☐	Colitis/Irritable Bowel
☐	☐	Epilepsy/seizures
☐	☐	Excessive/heavy bleeding
☐	☐	Heart Attack
☐	☐	Heart Failure
☐	☐	Heart Murmur
☐	☐	Heavy Drinking
☐	☐	Hepatitis
☐	☐	Kidney Stones
☐	☐	Liver disease
☐	☐	Lung disease/pneumonia
☐	☐	Rheumatic fever
☐	☐	Stroke
☐	☐	Thyroid trouble
☐	☐	Tuberculosis
☐	☐	Tumors
☐	☐	Ulcers (Gastrointestinal)

NAME _____

(Please check yes or no)

YES/NO Head and Neck

- ☐ ☐ Do you have migraine/severe headaches?
- ☐ ☐ Do you have severe dizziness?
- ☐ ☐ Have you fainted in the past 12 months?
- ☐ ☐ Are you generally a nervous person?
- ☐ ☐ Do you have an eye disease?
- ☐ ☐ Do you wear corrective lenses?
- ☐ ☐ Are you hard of hearing?
- ☐ ☐ Do you have ringing in your ears?
- ☐ ☐ Have you had a recent ear infection?
- ☐ ☐ Do you have sinus trouble or allergies?
- ☐ ☐ Have you had hoarseness?
- ☐ ☐ Do you have trouble swallowing?
- ☐ ☐ Does swallowed food come back up?
- ☐ ☐ Have you had swollen neck glands?

Heart and Lungs

- ☐ ☐ Do you have chest pain with exercise?
- ☐ ☐ Do you get short of breath often?
- ☐ ☐ Do you have a frequent cough?
- ☐ ☐ Do you cough up mucous?
- ☐ ☐ Do you have to sleep upright in a chair?
- ☐ ☐ Are your ankles often definitely swollen?
- ☐ ☐ Do you get leg cramps when walking?
- ☐ ☐ Do your feet get cold or numb?
- ☐ ☐ Are you bothered by palpitations (pounding of the heart)?

YES/NO Skin

- ☐ ☐ Have you had a severe skin rash?
- ☐ ☐ Have any moles or growths recently changed in size or bothered you?

GI tract

- ☐ ☐ Are you troubled by abdominal pain?
- ☐ ☐ Are you troubled by frequent nausea?
- ☐ ☐ Are you troubled by vomiting?
- ☐ ☐ Have you ever vomited blood?
- ☐ ☐ Are you troubled by excessive gas?
- ☐ ☐ Are you troubled by frequent diarrhea?
- ☐ ☐ Are you troubled by frequent constipation?
- ☐ ☐ Do you use laxatives regularly?
- ☐ ☐ Do you have hemorrhoids?
- ☐ ☐ Have you ever had bloody stools?
- ☐ ☐ Have your bowel movements changed recently in size, appearance, frequency?

_____ Number of bowel movements per day.

GU tract

- ☐ ☐ Do you have trouble starting the urine?
- ☐ ☐ Do you sometimes lose control of urine?
- ☐ ☐ Have you passed blood in your urine?

_____ Number of times you urinate at night.

_____ Number of times you urinate during the day.

MEDICATIONS

Daily Aspirin: _____ mg/day Daily Vitamins: ____/day types: _____

*Please list any other **medications** you are presently taking:*

MEDICATION	DOSAGE	TIME WHEN TAKEN

NAME _____

SURGERY

Please list all previous surgeries and hospitalizations:

PROCEDURE/DIAGNOSIS	DATE	HOSPITAL NAME/LOCATION

EXERCISE

	YES	NO
Do you enjoy exercising?	☐	☐
Have you exercised regularly in the past?	☐	☐

How often do you exercise presently? _____ times/week
_____ minutes/session

Have you exercised at any gyms, clubs, or spas, or play on any team sports now or in the past?
If yes, please describe: _____

Are you limited during exercise by shortness of breath, dizziness, or chest discomfort?
If yes, please describe: _____

Are you limited during exercise by joint pain or swelling, muscle pain, back pain, torn ligaments?
If yes, please describe: _____

FOR WOMEN ONLY

Date of last menstrual period: _____
Date of last mammogram: _____
Date of last PAP smear: _____
Number of pregnancies: _____
Number of live births: _____

	YES	NO	
Are you pregnant now?	☐	☐	If yes, due date: _____
Are you using any form of birth control?	☐	☐	If yes, what type: _____
Are you taking hormone replacement?	☐	☐	If yes, what type: _____
Are your menstrual periods painful?	☐	☐	If yes, how often: _____
Are your menstrual periods irregular?	☐	☐	If yes, date of onset: _____
Have you had hot flashes?	☐	☐	If yes, date of onset: _____

NAME _____

HABITS

	YES	NO	
Are you on a special diet?	☐	☐	If yes, please describe:_____
Have you ever smoked cigarettes?	☐	☐	Age started: ___ Age quit: _____
Are you currently a smoker?	☐	☐	If yes, packs/day: _____

How much do you consume of the following:

Beer ____ 12 oz cans per week
Wine ____ 4 oz glasses per week
Liquor ____ 2 oz drinks per week
Tea ____ cups per day
Coffee (decaffeinated)____ cups per day
Coffee (regular)____ cups per day

Where do you eat most of your meals?

- ☐ Home
- ☐ Restaurant
- ☐ Other (please explain) _____

With whom do you usually eat?

- ☐ Alone
- ☐ With Family
- ☐ Other (please explain) _____

	YES	NO
Is any member of your household on a special diet?	☐	☐

If so, please describe: _____
Who usually prepares the food you eat at home? _____

Please list any discomforts or allergies to foods:

_____
_____
_____

What are some of your favorite foods?

_____
_____
_____

Please explain your usual taste preferences and eating habits *(sweets, salty, binge eater, stress, etc.)*

_____
_____
_____
_____
_____

FAMILY HISTORY NAME _____

Please indicate which, if any, of your family members had the following conditions:

	Sibling	Mother	Father	Aunt/Uncle	Grandparent
ANEMIA	☐	☐	☐	☐	☐
BLEEDING PROBLEMS	☐	☐	☐	☐	☐
BLOOD CLOTS	☐	☐	☐	☐	☐
CANCER (BREAST)	☐	☐	☐	☐	☐
CANCER (COLON)	☐	☐	☐	☐	☐
CANCER (OTHER)	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
GALLSTONES	☐	☐	☐	☐	☐
GOUT	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐
OBESITY	☐	☐	☐	☐	☐
SLEEP APNEA	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐

	YES	NO	
Is your father living?	☐	☐	If not, cause of and age at death: _____
Is your mother living?	☐	☐	If not, cause of and age at death: _____

Please list any family members who are obese and their maximum weight:

_____

_____

_____

GENERAL

	YES	NO
Do you live alone?	☐	☐
Are you responsible for an invalid?	☐	☐
Are you presently involved in any lawsuit	☐	☐
related to an injury or operation?	☐	☐
Do you often feel pressed for time?	☐	☐

How often do you wake up in the middle of the night? _____

How often does your work leave you feeling exhausted? _____

How many times per week do you feel angry or frustrated? _____

How did you find out about us?

- ☐ Internet
- ☐ Friend or relative
- ☐ Patient
- ☐ Health professional
- ☐ Other _____

Education: *(check all that apply)*

- ☐ High school
- ☐ Some College
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- Doctorate

NAME_____

Household members: *(please include ages)*

Please write about you! *(relationships, marriage, children, etc…)*

How does your family feel about you having this surgery?

Please list your activities *(out of home)*:

Please list major personal interests:

How does your weight affect you socially?

How does your weight affect you physically?

Please list any publications which you frequently read *(magazines, newspapers, etc…)*

NAME _____

What are your concerns about your own health?

_____
_____
_____
_____
_____

What are your concerns or fears about the surgery?

_____
_____
_____
_____
_____

PATIENT AGREEMENT

IF YOU ARE ACCEPTED FOR SURGERY, THE FOLLOWING ARE VERY IMPORTANT TO MAINTAIN GOOD HEALTH AND TO ACHIEVE THE DESIRED WEIGHT LOSS.

	YES	NO
Are you willing to avoid foods and beverages containing sugar?	☐	☐
Are you willing to never use tobacco products?	☐	☐
Alcohol causes gastric irritation and liver damage. After surgery, frequent alcohol consumption is unwise and can be harmful. Are you willing to have **no alcohol for at least one year** after surgery, and to use alcohol only on a very limited basis thereafter?	☐	☐
Are you willing to make a commitment for regular lifelong medical follow-up?	☐	☐

PATIENT SIGNATURE: _____ DATE: _____

NOTE: At the time of your visit it is very helpful to review recent medical evaluations and any laboratory studies which you may have had recently performed. Please bring copies with you or request that they be sent by mail or fax prior to the date scheduled for your consultation.

Thank you