

Name: _____ DOB: _____ Age: _____

Email Address: _____

PRESENT ILLNESS (Please answer all the questions listed below)

1. In your own words, state your reason for coming to see the doctor today (chief complaint): _____

2. Have you seen other doctors for weight loss surgery or weight loss? Who? _____

3. How long has excess weight been a problem? _____

4. Can you identify health problems or quality of life issues directly related to the excess weight? _____

5. On a scale of 0-10 (low to high), how severe would you rate your excess weight? _____
6. On a scale of 0-10 (low to high), how would you rate the impact of excess weight on your health and/or quality of life? _____
7. How frequently does the excess weight impact your health and/or quality of life? _____

8. How have you learned to deal or cope with the excess weight? _____

9. Can you identify a health problem or life-style issue that may be contributing to the problem of excess weight? _____

10. Is the problem of excess weight potentially related to another health issue? _____

11. What has worked in the past to help you lose weight? _____

12. What has not worked in the past to help you lose weight? _____

OTHER DOCTORS (Please list other doctors who have been involved in your medical care)

- | Doctor Name | Type of Doctor (reason seen) | Office Telephone |
|---|------------------------------|------------------|
| 1. Dr. _____ | _____ | _____ |
| 2. Dr. _____ | _____ | _____ |
| 3. Dr. _____ | _____ | _____ |
| 4. How many times have you seen your primary care doctor in the last 2 years? _____ | | |
| 5. How many times have you been in the emergency room in the last 2 years? _____ | | |

Name: _____

DOB: _____

MEDICAL HISTORY (Please check [X] all medical conditions you have or have had in the past.)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Chronic Pancreatitis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> CPAP |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Bi-PAP |
| <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hip, <input type="checkbox"/> Knee, <input type="checkbox"/> Ankle, <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Depression | <input type="checkbox"/> Infertility | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Diabetes or <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Urinary Stress Incontinence |
| <input type="checkbox"/> Portal Hypertension | <input type="checkbox"/> Esophageal dysmotility | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Shortness of Breath with Exertion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn/Reflux | | |
| | <input type="checkbox"/> Hiatal Hernia | | |

Additional Medical History (Please check all medical conditions you have or have had in the past.)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Immune System Disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Breast Mass | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Sjogrens Syndrome |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cancer (Type) _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems |
| _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical/Drug Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Clotting Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Reaction to Anesthesia | <input type="checkbox"/> Other: _____ |

SURGICAL HISTORY (Please list all surgical procedures you have had in the past)

NAME OF OPERATION	YEAR	NAME OF OPERATION	YEAR
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

FAMILY MEDICAL HISTORY (Please check [x] all medical conditions your blood relatives have.)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Clotting Disorders | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Hepatitis | |

Other: _____

SOCIAL HISTORY (Please answer all the questions below)

Occupation: _____ Marital Status: _____

- | | | | |
|---|--|----------------|--|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you quit? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you or did you drink excessive alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you quit? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use or have you used recreational drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you quit? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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REVIEW OF SYSTEMS (Please check [x] symptoms that you have had or may be experiencing)

General/Constitution

- Decreased appetite
- Fatigue
- Fever
- Weight - Gain/Loss

Skin/Breast

- Breast mass
- Hives
- Nipple discharge
- Rashes

Ear, Nose & Throat

- Bleeding gums
- Constant throat clearing
- Difficulty swallowing
- Frequent sore throat
- Hoarseness
- Loss of hearing
- Mouth Sores
- Nasal congestion
- Nosebleeds
- Ringing in ears

Hematological

- Bleeding tendency
- Clotting tendency

Eyes

- Pain
- Loss of vision
- Double vision
- Blurred vision
- Flashing spots/light
- Glasses

Cardiovascular

- Chest pain with activity
- Chest pain at rest
- Heart palpitations
- Irregular heart beat
- Leg swelling
- Shortness of breath with activity
- Shortness of breath at rest

Respiratory

- Chronic cough
- Coughing up blood
- Home O₂ (oxygen)
- Pneumonia
- Pulmonary Embolism
- Night Sweats
- Wheezing

Gastrointestinal

- Nausea
- Vomiting blood
- Heartburn
- Regurgitation
- Difficulty swallowing
- Pain with swallowing
- Constipation
- Yellow jaundice
- Stomach pain
- Blood in stools
- Black tarry stools
- Hemorrhoids
- Need for laxative/enema use
- Diarrhea

Genitourinary

- Difficult urination
- Blood in urine
- Discharge from penis/vagina
- Frequent night urination
- Frequent urination
- Kidney Stones
- Painful urination
- Prostate troubles
- Urgency
- Anemia

Neurological

- Arm / Leg weakness
- Convulsions
- Dizziness
- Fainting
- Headaches
- Memory Loss

Endocrine

- Fingernail changes
- Flushing
- Heat/cold intolerance
- Increased thirst
- Increased salt intake

Immunologic

- Latex allergy
- Rhinitis
- Skin sensitivity

Psychiatric

- Depression
- Panic attacks
- Psychological counseling

IN THE LAST 5 YEARS HAVE YOU HAD: (Please check (X) all that apply.)

Heart work-up / tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
• Echo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____
• Stress Test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____
• Cardiac Catherization	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____
Lung work-up / tests:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
• Chest X-ray	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____
• Pulmonary Function Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____
• Coumadin/Lovenox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____	Location: _____

IMPORTANT REMINDERS

Did you check if your insurance company covers weight loss surgery? No Yes: _____

What type of provider does your insurance company consider us as: in network out of network non-participating preferred

Do you have a copy of your insurance pre-certification criteria for weight loss surgery? No Yes _____

Name: _____

DOB: _____

DIETING HISTORY – Last 2 years only (*Must be filled out* – list all diet and exercise attempts, use extra sheet if needed.)

Diet Program (Diet programs/exercise/drugs)	Year	Supervised (By a M.D. / Dietician)	
--	------	---------------------------------------	--

Diet Programs:

- | | | | |
|---|-------|-----|----|
| <input type="checkbox"/> Advocate | _____ | Yes | No |
| <input type="checkbox"/> American Diabetic | _____ | Yes | No |
| <input type="checkbox"/> American Heart Association | _____ | Yes | No |
| <input type="checkbox"/> Atkins | _____ | Yes | No |
| <input type="checkbox"/> Blood Type | _____ | Yes | No |
| <input type="checkbox"/> Body for Life | _____ | Yes | No |
| <input type="checkbox"/> Cabbage Soup | _____ | Yes | No |
| <input type="checkbox"/> Diet Center | _____ | Yes | No |
| <input type="checkbox"/> E-Diet | _____ | Yes | No |
| <input type="checkbox"/> Fit for Life | _____ | Yes | No |
| <input type="checkbox"/> Grapefruit | _____ | Yes | No |
| <input type="checkbox"/> Health Strategies | _____ | Yes | No |
| <input type="checkbox"/> High Protein | _____ | Yes | No |
| <input type="checkbox"/> Hollywood Liquid | _____ | Yes | No |
| <input type="checkbox"/> Jenny Craig | _____ | Yes | No |
| <input type="checkbox"/> LA Weight Loss | _____ | Yes | No |
| <input type="checkbox"/> Low Calorie | _____ | Yes | No |
| <input type="checkbox"/> Low Carbohydrate | _____ | Yes | No |
| <input type="checkbox"/> Low Fat | _____ | Yes | No |
| <input type="checkbox"/> Metabolic Type | _____ | Yes | No |
| <input type="checkbox"/> Michael Thurmond | _____ | Yes | No |
| <input type="checkbox"/> Nutrisystem | _____ | Yes | No |
| <input type="checkbox"/> Omni-Trim | _____ | Yes | No |
| <input type="checkbox"/> Optifast | _____ | Yes | No |
| <input type="checkbox"/> Out-of-Eden | _____ | Yes | No |
| <input type="checkbox"/> Physician's Weight Loss | _____ | Yes | No |
| <input type="checkbox"/> Rachel Ray | _____ | Yes | No |
| <input type="checkbox"/> Release the Fat | _____ | Yes | No |
| <input type="checkbox"/> Scarsdale | _____ | Yes | No |
| <input type="checkbox"/> Six-Week Body Makeover | _____ | Yes | No |
| <input type="checkbox"/> Slim-4-Life | _____ | Yes | No |
| <input type="checkbox"/> Slimfast | _____ | Yes | No |
| <input type="checkbox"/> Starvation | _____ | Yes | No |
| <input type="checkbox"/> Suzanne Summers | _____ | Yes | No |
| <input type="checkbox"/> Tops | _____ | Yes | No |
| <input type="checkbox"/> Weight Watcher's | _____ | Yes | No |
| <input type="checkbox"/> Zone | _____ | Yes | No |
| <input type="checkbox"/> Other: _____ | _____ | Yes | No |

Diet Program (Diet programs/exercise/drugs)	Year	Supervised (By a M.D. / Dietician)	
--	------	---------------------------------------	--

Prescription Medications:

- | | | | |
|--------------------------------------|-------|-----|----|
| <input type="checkbox"/> Adipex | _____ | Yes | No |
| <input type="checkbox"/> Didrex | _____ | Yes | No |
| <input type="checkbox"/> Fhen-Phen | _____ | Yes | No |
| <input type="checkbox"/> Ionamin | _____ | Yes | No |
| <input type="checkbox"/> Meridia | _____ | Yes | No |
| <input type="checkbox"/> Phentermine | _____ | Yes | No |
| <input type="checkbox"/> Tenuate | _____ | Yes | No |
| <input type="checkbox"/> Xenical | _____ | Yes | No |

Over-the-Counter Meds:

- | | | | |
|---|-------|-----|----|
| <input type="checkbox"/> AB-B-Gone | _____ | Yes | No |
| <input type="checkbox"/> Alli | _____ | Yes | No |
| <input type="checkbox"/> Cortislim | _____ | Yes | No |
| <input type="checkbox"/> Dexatrim | _____ | Yes | No |
| <input type="checkbox"/> Envy | _____ | Yes | No |
| <input type="checkbox"/> Ephedra | _____ | Yes | No |
| <input type="checkbox"/> Fahrenheit | _____ | Yes | No |
| <input type="checkbox"/> Fastin | _____ | Yes | No |
| <input type="checkbox"/> Flush the Fat | _____ | Yes | No |
| <input type="checkbox"/> Ginko Biloba | _____ | Yes | No |
| <input type="checkbox"/> Ginseng | _____ | Yes | No |
| <input type="checkbox"/> Grapefruit pills | _____ | Yes | No |
| <input type="checkbox"/> Green Tea pills | _____ | Yes | No |
| <input type="checkbox"/> Herbal Life | _____ | Yes | No |
| <input type="checkbox"/> Hoodia | _____ | Yes | No |
| <input type="checkbox"/> Hydroxycut | _____ | Yes | No |
| <input type="checkbox"/> Leptopril | _____ | Yes | No |
| <input type="checkbox"/> Lipozene | _____ | Yes | No |
| <input type="checkbox"/> Medifast | _____ | Yes | No |
| <input type="checkbox"/> Metabolife | _____ | Yes | No |
| <input type="checkbox"/> Relacore | _____ | Yes | No |
| <input type="checkbox"/> Slim Quick | _____ | Yes | No |
| <input type="checkbox"/> Stacker-2 | _____ | Yes | No |
| <input type="checkbox"/> Trimspa | _____ | Yes | No |
| <input type="checkbox"/> Xenidrine | _____ | Yes | No |
| <input type="checkbox"/> Zantrex-3 | _____ | Yes | No |

Exercise:

- | | | | |
|---|-------|-----|----|
| <input type="checkbox"/> Bally / Gold's Gym | _____ | Yes | No |
| <input type="checkbox"/> Curves | _____ | Yes | No |
| <input type="checkbox"/> YMCA | _____ | Yes | No |
| <input type="checkbox"/> Other: _____ | _____ | Yes | No |

OTHER PHYSICIAN SUPERVISED DIETS: (Please list any other physician supervised diets you have attempted.)
