



Surgical Weight Loss Program

**Patient Information**

Patient Name: \_\_\_\_\_

(Last), (First) (Middle)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F Marital Status: M D S W

Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Primary Insurance**

Insurance Company Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Customer Service Phone Number: \_\_\_\_\_

**Secondary Insurance**

Insurance Company Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Customer Service Phone Number: \_\_\_\_\_

## General Information

How did you hear about this program? \_\_\_\_\_

Are you seeking surgical evaluation for severe obesity?  No  Yes

Does your Primary Care Physician know about your interest in this surgery?  No  Yes

Does your Physician feel this surgery would be a good treatment for you?  No  Yes

## Weight and Diet History

Current age \_\_\_\_\_ Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_

Approximate age when you developed a significant weight problem? \_\_\_\_\_

What is the most that you have ever weighed? \_\_\_\_\_

In your opinion, what has contributed to your problem with obesity?

\_\_\_\_\_

Have you ever been treated for an eating disorder (anorexia, bulimia, binge-eating)?  No  Yes

If yes, type of treatment program \_\_\_\_\_ Year(s) treated \_\_\_\_\_

## Food Preferences

Please indicate which foods you prefer (which foods would most likely make you go off a diet). Rank selections from 1 (like very much) to 4 (don't care).

\_\_ Soda/Soft Drinks    \_\_ Steaks/Chops    \_\_ French Fries    \_\_ Pasta  
\_\_ Chocolate    \_\_ Pizza    \_\_ Chips/Snacks    \_\_ Fried Foods  
\_\_ Candy    \_\_ Cakes/Pies/Cookies    \_\_ Salad Dressings    \_\_ Potatoes

List all diet programs and weight loss attempts you have tried. Please be specific (Jenny Craig, Weight Watchers, Dietitian, medications, etc.) This information will be used for insurance qualification for surgery.

Program or diet	Dates	How long?	MD supervised	Maximum loss

## Names of Doctors Caring for You

Physician Type	Physician Name	Address	Phone Number	Last Seen
PCP				
Internist				
OB/GYN				
Orthopedist				
Cardiologist				
Pulmonologist				
Endocrinologist				
Psychiatrist				
Psychologist/Counselor				
Urologist				
Other				
Other				

## Review of Systems

Please check all symptoms which you have currently or on a chronic (ongoing/recurring) basis. Write in any additional problems not listed.

### Endocrine

- Low thyroid
- X-ray to thyroid
- Hyperthyroid
- Diabetes
- Goiter
- Adrenal gland tumor
- Grave's disease
- Frequent flushing
- Thyroid nodules
- Frequent heavy sweating

### Psychological

- Depression
- Nervousness
- Hospitalization for emotional problems
- Anxiety
- Psychiatric treatment
- Thoughts of suicide
- Psychological counseling
- Suicide attempts

**Head, Eye, Ears, Nose, and Throat**

- Sore throat
- Headache
- Blurry Vision
- Stuffy Nose
- Buzzing in ears
- Vertigo
- Hoarseness
- Runny nose
- Ringing in ears
- Loss of balance
- Hay fever
- Double vision
- Discharge from ears
- Sinus trouble
- Halos around lights
- Trouble swallowing
- Earache
- Loss of night vision
- Dizziness
- Pain with swallowing

**Respiratory**

- Cough
- Wheezing
- Bloody sputum
- Use two pillows
- Asthma
- Bronchitis
- Shortness of breath at night
- Out of breath with exertion
- Wake up at night short of breath
- Wake up at night coughing or choking

**Cardiovascular**

- Chest Pain
- Heart Murmur
- Chest Tightness
- Irregular Heart Beat
- Palpitations
- Pains in arms
- Blue finger(s)
- Pounding of heart
- Loss of pulses
- Skipping of heartbeat
- Heart attack
- Pain in legs
- Cold feet
- Pains in neck
- Abnormal Electrocardiogram

**Gastrointestinal**

- Nausea
- Vomiting
- Heartburn
- Black, tarry stools
- Constipation
- Diarrhea
- Bloody Stool
- Pains in stomach
- Food sticking in chest
- Fissures
- Exposure to hepatitis A, B, or C
- Cramps
- Burning in stomach
- Hemorrhoids
- Gassiness
- Belching fluid in throat
- Acid stomach
- Pain with bowel movement
- Irritable colon
- Burning in throat
- Colitis

**Urinary**

- Pain with urination
- Frequency
- Blood in urine
- Kidney stones
- Trouble starting urine
- Bladder stones
- Getting up at night to urinate
- Trouble stopping urine
- Kidney failure
- Small urine stream
- Nephritis
- Leakage of urine with cough or sneeze
- Urinary tract infections

**Male**

- Discharge from penis
- Loss of erection
- Painful of erection

**Female**

- Irregular periods
- Pain with intercourse
- Vaginal Bleeding
- Vaginal Discharge

**Musculoskeletal**

- Joint Pain
- Back Pain
- Joint Swelling
- Fluids in joints
- Slipped disc
- Redness of skin over joints
- Broken bones
- Ankle pain
- Sciatica
- Sprains
- Foot pain
- Warm joints
- Flat feet

- Fits
- Falling to the side
- Shakiness
- Falling at night
- Weakness of any muscles
- Tremor
- Fainting

**Hematology**

- History of blood transfusion
- Abnormal bleeding disorder
- AIDS/HIV exposure

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**Neurological**

- Dizziness
- Loss of Consciousness
- Numbness
- Tingling
- Twitching of muscles
- Convulsions
- Vertigo
- Pins and needles feelings
- Weakness of grip

**Medical History**

Please check illness or symptoms and complete information as appropriate.

**Cardiovascular**

- Angina    Heart Attack    Abnormal EKG    Palpitations    Stress Test
- Heart Murmur  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_
- High Blood Pressure  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_
- High Cholesterol  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_
- Venous Stasis Disease  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_
- Blood Clots in legs    Blood Clots in lungs  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_

**Endocrine**

- Diabetes  
Year Diagnosed \_\_\_\_\_ Treatment    Diet    Pills    Insulin  
Blood sugars taken \_\_\_\_\_ times a day   Last Hgb A1C \_\_\_\_\_
- Gestational    Type I    Type II    Neuropathy
- Thyroid Disease  
 High    Low   Type \_\_\_\_\_  
Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_

Respiratory

- Asthma
  - Year Diagnosed \_\_\_\_\_ Treatment  Medication  Inhalers  Aerosols
  - Last Steroid use \_\_\_\_\_ Number of hospitalizations in the last 2 years \_\_\_\_\_
  - Number of ER visits in the last 2 years \_\_\_\_\_ Oxygen dependent?  No  Yes
- Sleep Apnea
  - Year Diagnosed \_\_\_\_\_ Sleep Study \_\_\_\_\_
  - Do you use a CPAP?  No  Yes CPAP settings? \_\_\_\_\_ cm
  - Do you suffer from?  Morning Headaches  Daytime Drowsiness
    - Restless Sleep  Snoring  Frequent night awakening
    - Observed episodes of breathing stopped while asleep
- Shortness of breath
  - Can walk \_\_\_\_\_ blocks on level ground or \_\_\_\_\_ number of stairs.

Gastrointestinal

- Heartburn  Reflux  Hiatal Hernia
  - Year Diagnosed \_\_\_\_\_ Treatment  Medication  Surgery
  - UGI Series  No  Yes Endoscopy  No  Yes
- Gallbladder Disease
  - Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_
- Irritable Bowel Syndrome
  - Year Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_

Urological

- Stress Incontinence
  - Year Diagnosed \_\_\_\_\_ Wear a pad?  Always  Frequently  Rarely

Orthopedic

- Low back pain
  - Seen by  Chiropractor  Family Doctor  Orthopedic Surgeon
  - Take pain or anti-inflammatory medication \_\_\_\_\_ times per  day  week
- Sciatica  Pain in hips  Pain in ankles  Pain in feet  Pain in knees
  - Diagnosed \_\_\_\_\_ Treatment \_\_\_\_\_

Psychological

- Nervousness  Anxiety  Depression  Thoughts of suicide  Suicide attempts

Any other Medical Conditions:

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**Allergy History**

- Foods  No  Yes \_\_\_\_\_
- Drugs  No  Yes \_\_\_\_\_
- Tapes  No  Yes \_\_\_\_\_
- Latex  No  Yes \_\_\_\_\_

## Family History

Family Member	Living	Age/Age at Death	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling (Brother/Sister)			
Sibling (Brother/Sister)			
Sibling (Brother/Sister)			

Please note any family member (please specify grandparent, sibling, and child) who has a history of:

	Grandmother /Grandfather	Mother	Father	Sibling (Brother/Sister)	Child (Son/Daughter)
Obesity					
High Blood Pressure					
Diabetes					
Heart Disease					
High Cholesterol					
Stroke					
Gallbladder Disease					
Cancer (Type)					
Lung Disease (asthma, emphysema)					
Kidney Disease					
Bleeding disorders					
Weight loss surgery (Type)					

## Surgical History

Please list any surgeries you have had and the year of the surgery.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you have a reaction to anesthesia?  No  Yes

If yes, please explain \_\_\_\_\_

## Lifestyle History

Occupation \_\_\_\_\_

Do you use tobacco (smoke, chew)?  No  Yes If yes, amount \_\_\_\_\_

Do you use alcohol? Socially  No  Yes Routinely  No  Yes

Do you use recreational drugs?  No  Yes

Have you ever been or are you currently being treated for substance abuse?  No  Yes

If yes, what type of program? \_\_\_\_\_ Year(s) treated \_\_\_\_\_

Do you exercise routinely?  No  Yes

If yes, what type and how frequently? \_\_\_\_\_

Are there any issues of support from family or friends that you feel may be a problem for you at the time of surgery or after?  No  Yes if yes, please explain \_\_\_\_\_

\_\_\_\_\_

## Medication History

Please list any medications you are currently taking, include over-the-counter medications and supplements.

Drug Name and Dosage

Frequency

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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