



Medical History

Date _____

Name _____ Social Security Number _____ - _____ - _____

DOB _____ Age _____ Height _____ Weight _____ BMI _____

Primary care doctor _____

For office use only

Height _____ Weight _____ BMI _____ Neck _____ Goal _____ Ideal _____

BMI > 45 _____ Age > 38 _____ Apnea _____ HbA1c _____ Insulin _____ Male _____

Past Medical History

Please circle the appropriate response

Bleeding	yes	no	Blood clots in the legs	yes	no
Rheumatic fever	yes	no	Blood clots to the lungs	yes	no
Thyroid problems	yes	no	Diabetes currently	yes	no
Tuberculosis	yes	no	Diabetes while pregnant	yes	no
Urinary tract infections	yes	no	Age at onset of diabetes		
Kidney disease	yes	no	Diabetes control	good	poor
Hepatitis	yes	no	Polycystic ovarian syndrome (PCOS)	yes	no
Do you have to take antibiotics before dental work	yes	no	Problems with anesthesia	yes	no
AIDS/HIV	yes	no	Hypertension (high blood pressure)	yes	no
			High cholesterol or triglycerides	yes	no

Past Surgical History

Please list all surgeries and approximate dates (year)

Past Hospitalizations

Please list all hospitalizations and approximate dates (year)

Review of Symptoms

General

Fevers	yes	no
Sweats	yes	no
Fatigue	yes	no
Loss of appetite	yes	no
Bloody sputum	yes	no
Persistent cough	yes	no

Skin

Rash	yes	no
Skin cancer	yes	no

Senses

Visual problems	yes	no
Hearing problems	yes	no
Ear ringing	yes	no

Neurological

Dizziness	yes	no
Migraines	yes	no
Seizures	yes	no
Strokes	yes	no
Memory loss	yes	no
Shaking	yes	no
Numbness	yes	no
Uncoordination	yes	no

Genito-urinary

Blood in urine	yes	no
Vaginal infections	yes	no
Stress urinary incontinence	yes	no
Bladder/kidney infections	yes	no
Prostate infections	yes	no

Sleep apnea

Snoring	yes	no
Require C-pap	yes	no
Daytime drowsiness	yes	no
Frequent waking at night	yes	no
Choking at night	yes	no
# of pillows used	_____	

Pulmonary disease

Short of breath on exertion	yes	no
Hay fever	yes	no
Emphysema/COPD	yes	no
Asthma	yes	no
Aspiration/choking	yes	no

Infection

HIV	yes	no
AIDS contact	yes	no
TB exposure	yes	no
Swollen glands	yes	no
Recurring infections	yes	no
Skin infections	yes	no

Exercise Limitations

Mild	yes	no
Moderate	yes	no
Severe	yes	no

Pain in joints

Back	yes	no
Hips	yes	no
Knees	yes	no
Feet	yes	no

Arthritis

Where	_____	
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Gastrointestinal

Heartburn/acid reflux	yes	no
Stomach pains	yes	no
Stomach ulcers	yes	no
Gastritis	yes	no
H. pylori infection	yes	no
Rectal bleeding	yes	no
Liver disease	yes	no
Hepatitis or cirrhosis	yes	no
Colitis or enteritis	yes	no
Stomach surgery	yes	no

Physical limitations

Climbing stairs	yes	no
Unusual fatigue	yes	no
Airline travel	yes	no
Lifting from floor	yes	no
Use of public seating	yes	no
Personal care	yes	no
Tying shoelaces	yes	no
Playing with children	yes	no

Gynecological

Last menstrual period	_____	
Pregnancies	_____	
Current contraception	_____	
Any chance you are currently pregnant	yes	no

Review of Symptoms (continued)

Cardiovascular

Heart attack	yes	no
Congestive heart failure	yes	no
Thrombophlebitis	yes	no
Swelling of ankles	yes	no
Chest pain	yes	no
Coronary heart disease	yes	no
Varicose veins	yes	no
Heart murmur	yes	no
Pulmonary embolism	yes	no
Stroke	yes	no
Ever taken Fen-Phen	yes	no

Psychological

Depression	yes	no
Feeling down	yes	no
Suicidal episodes	yes	no
Mood swings for days at a time	yes	no
Hospitalized for psychiatric reasons	yes	no
Use alcohol or drugs to cope	yes	no
Eating disorder	yes	no
Vomiting to lose weight	yes	no
Fasting to lose weight	yes	no
Laxatives to lose weight	yes	no
Life more stable than a year ago	yes	no
History of sexual abuse	yes	no
Psychiatric medications in past or present	yes	no
Overeat in reaction to feelings	yes	no
Is your spouse or significant other supportive of weight loss surgery	yes	no
Age you first became overweight	_____	

Epworth Sleepiness Scale

Note: the Epworth Sleepiness scale refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

<u>Scale</u>	<u>Situation</u>	<u>Likelihood</u>
0 = would never doze	Sitting and reading	_____
1 = slight chance of dozing	Watching TV	_____
	Sitting, inactive in a public place	_____
2 = moderate chance of dozing	As a passenger in a car for 1 hour, no break	_____
3 = high chance of dozing	Lying down to rest in the afternoon when circumstances permit	_____
	Sitting and talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In a car, stopped in traffic	_____

Medications

List all daily medications including over-the-counter medications and vitamins, herbs or supplements

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	No

Allergies

Please list any known allergies or sensitivities

Medication allergies

Other allergies

Sensitive or allergic to

Latex	yes	no	Iodine	yes	no
Dye	yes	no	Tape	yes	no

Weight Loss History

Please check all that apply.

Non-Supervised Attempts

Body For Life/Bill Phillips	
Gloria Marshall	
Health spa	
High protein	
Hypnosis	
Low carbohydrate	
Low fat	
Calorie counting on my own	
Gym membership	
Home gym equipment	

Atkins Diet	
AYDS	
Mayo Clinic Diet	
Pritikin	
Richard Simmons	
Scarsdale Diet	
Stillman Diet	
Sugar Busters	
Slim Fast	
South Beach Diet	
Other	

Supervised Weight Loss Attempts

Diet Pills From MD	
Diet Shots From MD	
Diet Center	
Overeaters Anonymous	
Optifast	
Weight Watchers	
Health Management Resources (HMR)	
Nutri-System	
T.O.P.S.	
Jenny Craig	
New Direction	
National Weight Loss	

Supervised Calorie Counting	
Acupuncture	
Psychological Counseling	
Weigh Of Life	
Weight Loss Center	
Exercise Counseling	
Medifast	
Metrical	
Nutritional counseling	
Personal Trainer	
Other	

Weight Loss Medications

Acutrim	
Adipex-P	
Amphetamines	
Anorex	
Benzphetamine	
Dexatrim	
Didrex	
Fastin	
Fenfluramine	
Herbal Remedies	
Ionamin	
Mazanor	
Meridia	
Metabolife	

Obalan	
Orlistat	
Phendiet	
Phentermine	
Phentrol	
Plegine	
Pondimin	
Redux	
Sanorex	
Tepanol	
Tenuate	
Wehless	
Xenical	
Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)	
Stomach stapling	
Vertical banded gastroplasty	

Gastric band	
Other	

Nutrition History

How many meals do you eat daily			
Do you snack between meals	yes		no
Do you drink soda	yes		no
Diet	yes		no
Regular	yes		no
How many sodas do you drink daily			

Food Preferences

Candy	yes	no	Fast food	yes	no
Cookies	yes	no	Seafood	yes	no
Fried food	yes	no	Cakes or pies	yes	no
Pizza	yes	no	Vegetables	yes	no
Chocolate	yes	no	Steak or red meat	yes	no
Chips and snacks	yes	no	Dairy products	yes	No
Food allergies					

Food Patterns

Please record the type of food and the amount you have eaten over the past two days.

	All foods eaten the day before yesterday
Before breakfast	
Breakfast	
Morning break	
Lunch	
Afternoon snack	
Dinner	
After dinner	
Before bed	
Other	