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### 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

<b>General</b>			<b>Infection</b>		
Fevers	yes	no	HIV	yes	no
Sweats	yes	no	AIDS contact	yes	no
Fatigue	yes	no	TB exposure	yes	no
Loss of appetite	yes	no	Swollen glands	yes	no
Bloody sputum	yes	no	Recurring infections	yes	no
Persistent cough	yes	no	Skin infections	yes	no
<b>Skin</b>			<b>Exercise Limitations</b>		
Rash	yes	no	Mild	yes	no
Skin cancer	yes	no	Moderate	yes	no
<b>Senses</b>			Severe	yes	no
Visual problems	yes	no	<b>Pain in joints</b>		
Hearing problems	yes	no	Back	yes	no
Ear ringing	yes	no	Hips	yes	no
<b>Neurological</b>			Knees	yes	no
Dizziness	yes	no	Feet	yes	no
Migraines	yes	no	<b>Arthritis</b>		
Seizures	yes	no	Where	_____	
Strokes	yes	no	<b>Gastrointestinal</b>		
Memory loss	yes	no	Heartburn/acid reflux	yes	no
Shaking	yes	no	Stomach pains	yes	no
Numbness	yes	no	Stomach ulcers	yes	no
Uncoordination	yes	no	Gastritis	yes	no
<b>Genito-urinary</b>			H. pylori infection	yes	no
Blood in urine	yes	no	Rectal bleeding	yes	no
Vaginal infections	yes	no	Liver disease	yes	no
Stress urinary incontinence	yes	no	Hepatitis or cirrhosis	yes	no
Bladder/kidney infections	yes	no	Colitis or enteritis	yes	no
Prostate infections	yes	no	Stomach surgery	yes	no
<b>Sleep apnea</b>			<b>Physical limitations</b>		
Snoring	yes	no	Climbing stairs	yes	no
Require C-pap	yes	no	Unusual fatigue	yes	no
Daytime drowsiness	yes	no	Airline travel	yes	no
Frequent waking at night	yes	no	Lifting from floor	yes	no
Choking at night	yes	no	Use of public seating	yes	no
# of pillows used	_____		Personal care	yes	no
<b>Pulmonary disease</b>			Tying shoelaces	yes	no
Short of breath on exertion	yes	no	Playing with children	yes	no
Hay fever	yes	no	<b>Gynecological</b>		
Emphysema/COPD	yes	no	Last menstrual period	_____	
Asthma	yes	no	Pregnancies	_____	
Aspiration/choking	yes	no	Current contraception	_____	
			Any chance you are currently pregnant	yes	no

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**Review of Symptoms (continued)**


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**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	_____	

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**Epworth Sleepiness Scale**


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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.

<b>Scale</b>	<b>Situation</b>	<b>Likelihood</b>
0 = would never doze	Sitting and reading	_____
1 = slight chance of dozing	Watching TV	_____
2 = moderate chance of dozing	Sitting, inactive in a public place	_____
3 = high chance of dozing	As a passenger in a car for 1 hour, no break	_____
	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	_____

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**Medications**


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*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

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**Allergies**


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*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		Atkins Diet	
Gloria Marshall		AYDS	
Health spa		Mayo Clinic Diet	
High protein		Pritikin	
Hypnosis		Richard Simmons	
Low carbohydrate		Scarsdale Diet	
Low fat		Stillman Diet	
Calorie counting on my own		Sugar Busters	
Gym membership		Slim Fast	
Home gym equipment		South Beach Diet	
		Other	

### Supervised Weight Loss Attempts

Diet Pills From MD		Supervised Calorie Counting	
Diet Shots From MD		Acupuncture	
Diet Center		Psychological Counseling	
Overeaters Anonymous		Weigh Of Life	
Optifast		Weight Loss Center	
Weight Watchers		Exercise Counseling	
Health Management Resources (HMR)		Medifast	
Nutri-System		Metrical	
T.O.P.S.		Nutritional counseling	
Jenny Craig		Personal Trainer	
New Direction		Other	
National Weight Loss			

### Weight Loss Medications

Acutrim		Obalan	
Adipex-P		Orlistat	
Amphetamines		Phendiet	
Anorex		Phentermine	
Benzphetamine		Phentrol	
Dexatrim		Plegine	
Didrex		Pondimin	
Fastin		Redux	
Fenfluramine		Sanorex	
Herbal Remedies		Tepanol	
Ionamin		Tenuate	
Mazanor		Wehless	
Meridia		Xenical	
Metabolife		Other	

### Previous Weight Loss Surgery

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

**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.*

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