

Medical History

Date: _____

Name: _____ Social Security _____

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 _____
Temp _____	HR _____	BP _____	/ _____		

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	Problems with anesthesia	YES	NO
Antibiotics for dental work?	YES	NO	Polycystic ovarian syndrome (PCOS)	YES	NO
AIDS/HIV	YES	NO	Hypertension/high BP	YES	NO
			High cholesterol or triglycerides	YES	NO

PAST SURGICAL HISTORY		PAST HOSPITALIZATIONS	
Please list all surgeries	Approx. date	Please list all hospitalizations	Approx. date

FOR OFFICE USE ONLY – PATIENT MEDICAL SUMMARY

Review of Symptoms

Please circle the appropriate response

GENERAL			INFECTION		
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
SKIN			EXERCISE LIMITATIONS		
Rash	YES	NO	Mild	YES	NO
Acanthosis nigricans	YES	NO	Moderate	YES	NO
Hirsute (excess body hair)	YES	NO	Severe	YES	NO
Acne	YES	NO	PAIN IN JOINTS		
Skin cancer	YES	NO	Back	YES	NO
SENSES			Hips	YES	NO
Visual problems	YES	NO	Knees	YES	NO
Hearing problems	YES	NO	Feet	YES	NO
Ear ringing	YES	NO	Arthritis	YES	NO
NEUROLOGICAL			Where?		
Dizziness	YES	NO	GASTROINTESTINAL		
Migraines	YES	NO	Heartburn/acid reflux	YES	NO
Frequent headaches	YES	NO	Stomach pains	YES	NO
Seizures	YES	NO	Stomach ulcers	YES	NO
Strokes	YES	NO	Gastritis	YES	NO
Memory loss	YES	NO	H. pylori infection	YES	NO
Shaking	YES	NO	Rectal bleeding	YES	NO
Numbness	YES	NO	Liver disease	YES	NO
Uncoordination	YES	NO	Hepatitis or cirrhosis	YES	NO
GENITO-URINARY			Colitis or enteritis	YES	NO
Blood in urine	YES	NO	Frequent diarrhea	YES	NO
Vaginal infections	YES	NO	Frequent constipation	YES	NO
Stress urinary incontinence	YES	NO	Crohn's disease	YES	NO
Bladder/kidney infections	YES	NO	Intestinal telangectasia	YES	NO
Prostate infections	YES	NO	Stomach surgery	YES	NO
SLEEP APNEA			PHYSICAL LIMITATIONS		
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
Number of pillows used: _____			Personal care	YES	NO
PULMONARY DISEASE			Tying shoelaces	YES	NO
Short of breath on exertion	YES	NO	Playing with children	YES	NO
Hay fever	YES	NO			
Emphysema/COPD	YES	NO			
Pneumonia	YES	NO			
Asthma/choking	YES	NO			
Aspiration/choking	YES	NO			

Review of Symptoms *(continued)*

GYNECOLOGICAL (females only)

Last menstrual period: _____
 Pregnancies: _____
 Current contraception: _____
 Currently pregnant? YES NO
 Intend pregnancy next 2 yrs? YES NO

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/psych. reasons	YES	NO
Use alcohol or drugs to cope	YES	NO
Hospitalized/substance abuse	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 1 yr. ago	YES	NO
If < 18 years old, history of frequent school absence	YES	NO
History of sexual abuse	YES	NO
Psychiatric medications in past or present	YES	NO
Overeat in reaction to feelings	YES	NO
Intend other weight loss surgery in the next year	YES	NO

Age you first become 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.

SCALE:	
0 =	Would never doze
1 =	Slight chance of dozing
2 =	Moderate chance of dozing
3 =	High chance of dozing

SITUATION	LIKELIHOOD
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
A passenger in a car for 1 hour, no break	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, stopped in traffic	_____
Lying down to rest in the afternoon when circumstances permit	_____

TOTAL SCORE: _____

Social History

Marital status: Single Married/partnered Divorced/separated Widowed

Religious preference: _____

Ethnic background: _____

Education: _____

Number of people living in your home: _____ Who? _____

What type of work or hobbies do you do? _____

What type of sports do you do? _____

Do you smoke? YES NO How many per day? _____ How often? _____

Do you drink? YES NO How many per day? _____ How often? _____

Do you use controlled substances? YES NO

How does your spouse/partner/family/friends/significant other feel about your weight loss surgery?

For adolescents only

Highest grade in school: _____

School performance: Excellent Very good Good Fair Poor

School name: _____

Are you sexually active? _____

Do you smoke marijuana? _____

Family History

DISEASE	WHICH FAMILY MEMBER HAD IT?	WHEN?	WAS IT FATAL?
Cancer (what type)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Diabetes	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Heart attack	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Severe obesity	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Weight Loss History

NON-SUPERVISED ATTEMPTS					
Body For Life/Bill Phillips	YES	NO	Atkins Diet	YES	NO
Gloria Marshall	YES	NO	AYDS	YES	NO
Health spa	YES	NO	Mayo Clinic Diet	YES	NO
High protein	YES	NO	Pritikin	YES	NO
Hypnosis	YES	NO	Richard Simmons	YES	NO
Low carbohydrate	YES	NO	Scarsdale Diet	YES	NO
Low fat	YES	NO	Stillman Diet	YES	NO
Calorie counting on my own	YES	NO	Sugar Busters	YES	NO
Gym membership	YES	NO	Slim Fast	YES	NO
Home gym equipment	YES	NO	South Beach Diet	YES	NO
			Other Diet	YES	NO
SUPERVISED WEIGHT LOSS ATTEMPTS					
Diet Pills From MD	YES	NO	Supervised calorie counting	YES	NO
Diet Shots From MD	YES	NO	Acupuncture	YES	NO
Diet Center	YES	NO	Psychological counseling	YES	NO
Overeaters Anonymous	YES	NO	Weigh Of Life	YES	NO
Optifast	YES	NO	Weight Loss Center	YES	NO
Weight Watchers	YES	NO	Exercise counseling	YES	NO
Health Management Resources	YES	NO	Medifast	YES	NO
Nutri-System	YES	NO	Metrical	YES	NO
T.O.P.S.	YES	NO	Nutritional counseling	YES	NO
Jenny Craig	YES	NO	Personal trainer	YES	NO
New Direction	YES	NO	National Weight Loss	YES	NO
WEIGHT LOSS MEDICATIONS					
Acutrim	YES	NO	Obalan	YES	NO
Adipex-P	YES	NO	Orlistat	YES	NO
Amphetamines	YES	NO	Phendiet	YES	NO
Anorex	YES	NO	Phentermine	YES	NO
Benzphetamine	YES	NO	Phentrol	YES	NO
Dexatrim	YES	NO	Plegine	YES	NO
Didrex	YES	NO	Pondimin	YES	NO
Fastin	YES	NO	Redux	YES	NO
Fenfluramine	YES	NO	Sanorex	YES	NO
Herbal Remedies	YES	NO	Tepanol	YES	NO
Ionamin	YES	NO	Tenuate	YES	NO
Mazanor	YES	NO	Wehless	YES	NO
Meridia	YES	NO	Xenical	YES	NO
Metabolife	YES	NO	Other	YES	NO
PREVIOUS WEIGHT LOSS SURGERY					
Gastric bypass (RNY or other)	YES	NO	Gastric band	YES	NO
Stomach stapling	YES	NO	Other	YES	NO
Vertical banded gastroplasty	YES	NO			

Nutrition History

How many meals do you eat daily? _____

Do you snack between meals? _____

YES NO

How many daily? _____

Do you drink soda? _____

YES NO

How many daily? _____

Diet

YES NO

Regular

YES NO

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/red meat	YES	NO
Chips/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 YESTERDAY	ALL FOODS EATEN THE DAY BEFORE YESTERDAY
Before breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon break		
Dinner		
After dinner		
Before bed		
Other		