

Personal Details

Name: _____ Given Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: [Home] _____ [Business] _____

Date of Birth: _____ Age: _____

Occupation: _____

Health Insurance Plan: _____

Membership Number: _____ Plan Number: _____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

1. Next of Kin

Name: _____ Relationship: _____

Address: _____

Telephone: [Home] _____ [Business] _____

2. Additional Contact

Name: _____ Relationship: _____

Address: _____

Telephone: [Home] _____ [Business] _____

3. Additional Contact

Name: _____ Relationship: _____

Address: _____

Telephone: [Home] _____ [Business] _____

Referral Information

Referring Physician: _____ **Date of Referral:** _____

Address: _____

Office Telephone: _____

Local Physician: _____

Address: _____

Office Telephone: _____

Specialist Physician/Surgeon: _____

Other Physician: _____

Social Profile

Family Structure:

Married: _____ **Single:** _____ **Divorced:** _____ **Widow/er:** _____ **Partner/Relationship:** _____

Children/Ages: _____

Support Persons/Friends: _____

Employment:

Are you currently employed? Yes _____ No _____

Are you full-time, part-time or casual? _____

If you are unemployed, what is the reason? _____

Are you actively looking for work? Yes _____ No _____

Has your weight made it difficult to find employment? Yes _____ No _____

If employed, please state what level of activity your job involves:

Little [sedentary job] _____ **Moderately active** _____ **Very active [laboring, etc]** _____

Social History:

Do you smoke? _____ If yes, _____ packs per day for _____ years
 Do you drink alcohol? _____ If yes, how much and what type? _____
 Are you a recovering alcoholic? _____
 Do you now use or do you have a history of use/abuse of recreational or street drugs? _____
 If yes, please explain: _____
 What health related activities do you take part in [exercise, massage, etc]? _____

 What do you do for recreation or fun? _____

Family Medical History:

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/ CHILD	OTHER RELATIVES	NO FAMILY HISTORY	DO NOT KNOW
Diabetes					
Heart Disease					
Gallstones					
Obesity					
Hypertension					
Cancer					
Bleeding Disorders					
Penicillin Allergy					
Latex Allergy					
High Cholesterol					
Reaction to Anesthesia					

Please list any other information with regard to your family history: _____

Personal Medical History

Please carefully fill out this section of the document. It is critical to demonstrate significant attempts at voluntary weight management. This section will enable us to assist you with filing with your insurance carrier, if you should request to do so.

Weight History:

Current Height: _____ Current Weight: _____

First time obesity noted: Age: _____ Weight: _____

When did you weight became a problem: Lifelong _____ High school _____
 After children _____ Later in life _____

Please place a check mark to indicate your weight for each age range:

AGE	NORMAL	OBESE	MORBIDLY OBESE [WEIGHT 100LBS OVER IDEAL]
Childhood [ages 1-10]			
Adolescence [ages 11-18]			
Young Adult [ages 19-30]			
Adult [ages 30-60]			

Allergies:

Please list any medication allergies that you have: _____

Current Medications:

Please list any prescription or non-prescription medications you are currently taking [including dosage and frequency]:

Past Surgical History:

Please list all previous surgeries that you have had [include dates of surgery if possible]:

Past Medical History:

Have you ever suffered with any of the following health problems?

	YES	NO	DETAILS
Diabetes			
Diabetes while pregnant			
Asthma			
Respiratory or breathing problems			
Arthritis or joint pain			
Back pain			
Kidney or urinary disorder			
Neurological disorder			
Psychological/nervous disorder			
Gallstones			
Reflux or heartburn			
Gastric or duodenal ulcer			
Hepatitis or liver disease			
High blood pressure			
Heart disease			
High cholesterol			
Anemia or bleeding disorder			
Thrombosis or clotting disorder			
Varicose veins or leg swelling			
Sleep apnea			
Lupus or autoimmune disorder			
Urinary stress incontinence			
Insomnia			
Depression			

Ladies Only:

Do you have regular periods? Yes _____ No _____

If not, please describe: _____

Do you have problems with excessively heavy periods? Yes _____ No _____

If yes, please describe: _____

Have you had difficulty conceiving in the past? Yes _____ No _____

Do you currently have problems with infertility? Yes _____ No _____

Have you suffered from excess body hair or acne? Yes _____ No _____

Have you been told by a doctor that you have polycystic ovaries? Yes _____ No _____

Have you had problems with pregnancy and/or childbirth? Yes _____ No _____

Have you had a caesarian section? Yes _____ No _____

How many children do you have? _____

How many times have you been pregnant? _____

Weight Loss Attempts:

Please list any physicians who have treated you for obesity in the past:

Name Address/Phone Dates of Treatment

Please complete the following table for us to better understand your attempts at weight loss [complete as accurately as possible and be specific]:

PROGRAM	YEAR[S]	WEIGHT LOSS	WEIGHT REGAINED	MONTHS ON PROGRAM	COST
Fen-Phen/Redux					
Xenical					
Meridia					
Other Rx					
Diet Centers					
Nutrisystem					
Weight Watchers					
Jenny Craig					
Metabolife					
Herbalife					
Richard Simmons					
Adkins					
Sugary Busters					
Slim for life					
Overeaters Annon.					
Hypnosis					
Acupuncture					
Nutritionist					
Psychotherapy					
Fad diets					
Others					

Sleep History

How many hours of sleep do you get a night? _____

Is there anything that keeps you awake at night? Yes _____ No _____

If yes, please provide details: _____

Would you consider the quality of your sleep is: Good _____ Fair _____ Poor _____?

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? Yes _____ No _____

Symptoms of Sleep Apnea

Please answer the following questions to the best of your ability.

1. How often do you snore?
Never _____ Occasionally _____ Frequently _____ Always _____
2. Do you wake during the night with a choking feeling?
Never _____ Occasionally _____ Frequently _____ Always _____
3. How often do you sleep more than 8 hours in a total 24 hour period?
Never _____ Occasionally _____ Frequently _____ Always _____
4. How often do you wake up more than once during the night?
Never _____ Occasionally _____ Frequently _____ Always _____
5. Do you have a headache when you wake up in the morning?
Never _____ Occasionally _____ Frequently _____ Always _____
6. Have you notice a reduction in your libido or sex drive?
Never _____ Occasionally _____ Frequently _____ Always _____
7. Do you feel sleepy during the day?
Never _____ Occasionally _____ Frequently _____ Always _____
8. Has anyone noticed that you momentarily stop breathing during your sleep?
Never _____ Occasionally _____ Frequently _____ Always _____
9. Do you fall asleep while reading?
Never _____ Occasionally _____ Frequently _____ Always _____
10. Do you wake up in the morning feeling confused?
Never _____ Occasionally _____ Frequently _____ Always _____
11. How often do you have a nap during the day?
Never _____ Occasionally _____ Frequently _____ Always _____
12. Do you feel sleepy in the evenings?
Never _____ Occasionally _____ Frequently _____ Always _____
13. Have you or anyone else noticed a change in your personality recently?
Never _____ Occasionally _____ Frequently _____ Always _____
14. How often do you doze off or fall asleep while driving?
Never _____ Occasionally _____ Frequently _____ Always _____

Breathing History

General:

Does being at work ever make your chest tight or wheezy? Yes _____ No _____

Have you ever had to change your job because it affected your breathing? Yes _____ No _____

Have you ever worked in a job which exposed you to vapors, gas or dust? Yes _____ No _____

Asthma:

Have you ever had asthma? Never _____ Current _____ In the past _____ Don't know _____

Have you ever had to spend a night in the hospital because of asthma or breathing problems?

Yes _____ No _____ Don't know _____

If yes, was it in the past 12 months? Yes _____ No _____

Have you visited a hospital or physicians office urgently because you had asthma?

Yes _____ No _____

Have you taken a course of steroids because of asthma or breathing problems?

Yes _____ No _____

Have you missed work or school because of asthma or breathing problems?

Yes _____ No _____

Cough and Shortness of Breath:

Do you usually have a cough? Yes _____ No _____

Do you usually bring up phlegm from your chest when you cough? Yes _____ No _____

Do you get short of breath on exertion? Yes _____ No _____

Do you get short of breath walking on flat surfaces? Yes _____ No _____

Do you get short of breath walking uphill or doing housework? Yes _____ No _____

Wheezing:

In the past 12 months, have you had wheezing in your chest? Yes _____ No _____

In the past 12 months, have you had an attack of wheezing that came on after you stopped exercising? Yes _____ No _____

In the past 12 months, have you had a feeling tightness in your chest on waking in the morning? Yes _____ No _____

Gastroesophageal Reflux/Indigestion

Do you have a history of heartburn or indigestion? Yes _____ No _____

If yes, how often do you have reflux during the day?

Many times a day _____ Everyday _____ Most days _____ Most weeks _____
Occasionally _____

How often do you suffer heartburn/indigestion during the night?

Many times a night _____ Every night _____ Most nights _____ Most weeks _____
Occasionally _____

What aggravates or causes your reflux? _____

Do you have difficulty swallowing? Yes _____ No _____

Does food ever get stuck? Yes _____ No _____

Does food or fluid reflux into your mouth? Yes _____ No _____

Do you vomit with reflux? Yes _____ No _____

Do you suffer from a hoarse voice? Yes _____ No _____

Do you suffer from recurrent sore throats? Yes _____ No _____

Do you suffer from a regular cough at night? Yes _____ No _____

Please list any treatments you may use for reflux/heartburn or indigestion:
