

MEDICAL HISTORY

Height: _____ Wt: _____ Desired wt: _____ #Yrs 80 lbs over ideal wt: _____

Previous Weight Loss Attempts (include fad diets, medications, commercial programs, counseling, etc.)

Type	How Long?	Results / Weight Loss

Your physician: _____ Ph #: _____

Address _____

Allergies: _____

Medications and dosage: _____

Nonprescription medications (include vitamins, herbs, aspirin, pain meds, supplements, etc)

Have you been diagnosed with:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> GERD(acid reflux) | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Asthma / lung disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Hernia (hiatal, navel, | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Groin, incisional) | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Kidney disease |

Cancer---Type & year _____

Other chronic conditions _____

SOCIAL HISTORY

Education: _____ Occupation: _____

Tobacco use: No Yes History -- Yr Started _____ Yr Quit _____

Alcohol use: Rarely Occasionally Weekly Daily

Illegal drug use: No Yes

Details _____

FEMALES

First period at age: _____ Periods: Normal – Irregular – Heavy – Long
Pregnancies: _____ Live births: _____ Miscarriages: _____
Birth control pills Hormone replacement For how long? _____

SURGICAL HISTORY

Surgeries: _____

Have you received blood or blood product transfusions? _____

Problems with anesthesia? _____ Bleeding? _____

Details _____

If you have had previous surgery for obesity please provide the operative report, and details
Surgeon _____

Procedure and date _____

FAMILY HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Obesity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Vascular disease/Stroke | <input type="checkbox"/> Diabetes | Cancer - If yes, type? _____ |
| <input type="checkbox"/> Asthma/lung disease | <input type="checkbox"/> Blood disease | Other _____ |

Do you have severe and/or frequent:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Pain after eating | <input type="checkbox"/> Crying easily |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Intolerance to fatty meals | |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Irregular heart beats | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Numbness of fingers/toes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Tremors/shaking | <input type="checkbox"/> Swelling of feet/ankles | <input type="checkbox"/> Bowel cramps | |
| <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Leakage of urine | |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bladder/kidney infections | |

I certify that all this information is, to the best of my knowledge, true and complete. I have not intentionally omitted any part of my medical history. I consent to the use of this information and other outcomes data in medical studies. This will be done anonymously, using only a code number.

Printed Name: _____

Signature: _____ Date: _____