



Please select surgery type below:

- Laparoscopic Adjustable Gastric Band (Lap-Band)
- Gastric Bypass
- Sleeve Gastrectomy
- Undecided

First Name: \_\_\_\_\_ Initial \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender:  Female  Male Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ @ \_\_\_\_\_

Please indicate the best number to reach you and leave a message (Please circle type of phone)

( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell Home Work

( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Cell Home Work

Employment status  Employed  Not Employed  Retired

If disabled, specify the year and cause: Year \_\_\_\_\_ Cause \_\_\_\_\_

Employer: \_\_\_\_\_

Do you have any special need?  Yes  No If yes please specify: \_\_\_\_\_ wheel chair \_\_\_\_\_ other

**Emergency Contact (Please Print)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**How did you hear about us?**

- Doctor/Specialist
- Patient/Friend
- Event
- Website/Internet
- TV/Radio
- Magazine/Print
- Insurance
- Other \_\_\_\_\_

**Please provide your Primary Care Physician's information**

Physician Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Practice Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Why did you decide it was time to lose weight or consider weight loss surgery?**

- Deteriorating health
- Poor quality of life
- Unable to participate in family activities
- Advise of physician
- Insurance/monetary issues
- Other If other, please specify below:

**Co-morbid/medical conditions**

Have you been diagnosed or treated for the following by a physician?

- Diabetes
- Sleep Apnea
- High Blood Pressure
- Cardiovascular Problems
- Gastric or Stomach Problems
- Heart Burn/Acid Reflux
- Joint Degeneration
- Depression

Any other medical conditions that you have been diagnosed or treated for? \_\_\_\_\_

**Do you have a history of MRSA?**    Yes    No

**Are you adopted?**    Yes    No   (If you answered "yes" you do not need to fill out the family history section below unless you have knowledge of your family history)

**FAMILY HISTORY – Please list relationship to you**

- Alcoholism \_\_\_\_\_    Yes    No
- Bleeding Disorder \_\_\_\_\_    Yes    No
- Diabetes Mellitus \_\_\_\_\_    Yes    No
- Heart Disease \_\_\_\_\_    Yes    No
- High Blood Pressure \_\_\_\_\_    Yes    No
- Kidney Disease \_\_\_\_\_    Yes    No
- Liver Problems \_\_\_\_\_    Yes    No
- Lung Problems \_\_\_\_\_    Yes    No
- Malignant Hyperthermia \_\_\_\_\_    Yes    No
- Mental Illness \_\_\_\_\_    Yes    No
- Obesity \_\_\_\_\_    Yes    No

**Family History of Cancer (Type)**    Yes    No

- Breast    Uterine    Ovarian    Prostate    Colon    Lung    Other \_\_\_\_\_

**Personal History of Cancer (Type)**    Yes    No

- Breast    Uterine    Ovarian    Prostate    Colon    Lung    Other \_\_\_\_\_

Is there anything else you would like to share that you feel might be applicable \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Mood Questionnaire**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response in numerical form.

	Not at all	Several Days	More than half the days	Nearly Everyday
	0	1	2	3
1. Little Interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling asleep, staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, feeling that you are a failure, or that you have let yourself, family and others down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you are moving around a lot more than usual				
9. Thinking that you would be better off dead or that you want to hurt yourself in some way				
<b>Totals</b>				

\* PHQ-9 ©Copyright 1999 Pfizer

<b>Total Score</b>	<b>Depression Severity</b>	Score _____
0-4	None	<b>*Determined by provider</b>
5-9	Mild	
10-14	Moderate	
15-19	Moderately Severe	
20-27	Severe	

**SURGICAL/HOSPITALIZATION RECORD**

List of Surgeries/Date/Year

Surgery Performed \_\_\_\_\_

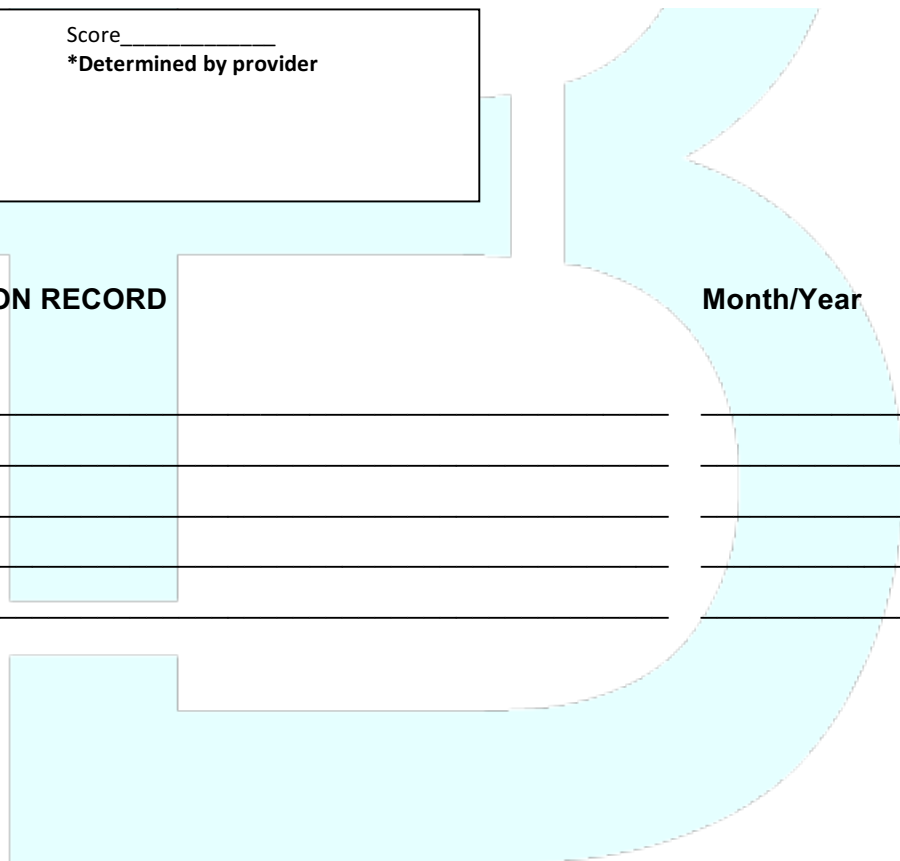
Surgery Performed \_\_\_\_\_

Surgery Performed \_\_\_\_\_

Surgery Performed \_\_\_\_\_

Surgery Performed \_\_\_\_\_

Month/Year



## REVIEW OF SYSTEMS

### Bladder/Kidney

- Kidney Stones  Yes  No
- Frequent UTIs  Yes  No
- Loss of bladder control (leakage)  Yes  No
- Kidney Insufficiency  Yes  No
- Kidney Failure  Yes  No
- Dialysis  Yes  No

### For Men: PSA test in the last year

- Prostate problems  Yes  No

### Blood

- Blood clot in leg  Yes  No
- Blood Clot in Lungs(pulmonary embolism)  Yes  No
- Bleeding disorder  Yes  No
- Blood transfusion  Yes  No
- Blood thinning medicine  Yes  No
- Anemia (vitamin B12 deficient)  Yes  No
- Anemia (iron deficient)  Yes  No
- HIV  Yes  No
- Low platelets (thrombocytopenia)  Yes  No

### Cardiovascular

- Angina (chest pain with activity)  Yes  No
- Heart attack  Yes  No
- Previous Angiogram  Yes  No
- Stent Placement  Yes  No
- PTCA (balloon angioplasty)  Yes  No
- Heart murmur  Yes  No
- Rheumatic fever/valve damage  Yes  No
- Rhythm disturbance/palpitations  Yes  No
- High blood pressure  Yes  No
- Congestive heart failure  Yes  No
- Ankle swelling  Yes  No
- Venous Stasis  Yes  No
- Ankle/Leg Ulcers  Yes  No
- Cramping in legs when walking  Yes  No

### Respiratory

- Asthma  Yes  No
- COPD  Yes  No
- Oxygen Dependent  Yes  No
- Recent Bronchitis  Yes  No
- Pneumonia  Yes  No
- Chronic cough  Yes  No
- Short of breath  Yes  No
- Tuberculosis  Yes  No
- Snoring  Yes  No
- Sleep apnea  Yes  No
- Hyperventilation syndrome  Yes  No

### Constitutional

- Fevers  Yes  No
- Night Sweats  Yes  No
- Anemia  Yes  No
- Weight Loss  Yes  No
- Chronic fatigue  Yes  No

- Hair Loss  Yes  No

### Endocrine

- Hypothyroid (low)  Yes  No
- Hyperthyroid (high/overactive)  Yes  No
- Goiter  Yes  No
- Parathyroid  Yes  No
- Elevated cholesterol  Yes  No
- Elevated triglycerides  Yes  No
- Low blood sugar  Yes  No
- Diabetes (managed by diet or pills)  Yes  No
- Diabetes (needing insulin shots)  Yes  No
- "Prediabetes" with elevated blood sugar  Yes  No
- Gout  Yes  No
- High calcium level  Yes  No

### Gastrointestinal

- Heartburn/ Acid Reflux  Yes  No
- Hiatal hernia  Yes  No
- Ulcers  Yes  No
- Unusual vomiting  Yes  No
- Change in bowel habit  Yes  No
- Diarrhea  Yes  No
- Constipation  Yes  No
- Gastritis  Yes  No
- Blood in stool  Yes  No
- Irritable bowel  Yes  No
- Colitis  Yes  No
- Crohns  Yes  No
- Polyps  Yes  No
- Cirrhosis/hepatitis  Yes  No
- Gallbladder problems  Yes  No
- Jaundice  Yes  No
- Pancreatic disease  Yes  No

### Head and Neck

- Wear contacts/glasses  Yes  No
- Vision problems  Yes  No
- Hearing problems  Yes  No
- Swallowing difficulty  Yes  No
- Dentures/partial  Yes  No
- Missing teeth  Yes  No
- Oral sores  Yes  No
- Hoarseness  Yes  No

### Musculoskeletal

- Arthritis  Yes  No
- Joint Pain  Yes  No
- Back Pain  Yes  No
- Shoulder Pain  Right  Left  Yes  No
- Ankle Pain  Right  Left  Yes  No
- Knee Pain  Right  Left  Yes  No
- Hip Pain  Right  Left  Yes  No
- Foot Pain  Right  Left  Yes  No
- Plantar fasciitis  Yes  No
- Carpal tunnel syndrome  Yes  No

Limited ability to walk  
Sciatica  
Muscle pain/spasm  
Broken bones  
Nerve injury  
Muscular dystrophy

Yes No  
Yes No  
Yes No  
Yes No  
Yes No  
Yes No

Stroke  
Alzheimer's  
Loss of vision from pressure in the brain  
Multiple Sclerosis  
Frequency severe headaches/migraines

Yes No  
Yes No  
Yes No  
Yes No  
Yes No

**Neurologic**

Balance disturbance  
Seizure or convulsions  
Weakness

Yes No  
Yes No  
Yes No

**Skin**

Rashes under skin folds  
Frequent skin infections  
Keloids (excessively raised scars)  
Poor wound healing

Yes No  
Yes No  
Yes No  
Yes No

**Psychiatric**

Anxiety  
Depression  
Anorexia (starvation to control weight)  
Bulimia (excessive vomiting to control weight)  
Bipolar disorder ("manic-depression")

Yes No  
Yes No  
Yes No  
Yes No  
Yes No

Alcoholism  
Drug dependency  
Schizophrenia  
Other psychiatric problems  
Have you ever attempted suicide?

Yes No  
Yes No  
Yes No  
Yes No  
Yes No

Have you ever been sexually abused?

Yes No

Have you ever been in a psychiatric hospital?

Yes No

If yes, please list facility \_\_\_\_\_  
Address/City/State \_\_\_\_\_

Phone \_\_\_\_\_  
Fax \_\_\_\_\_

Have you ever seen a psychiatrist?

Yes No

If yes, please list provider \_\_\_\_\_  
Address/City/State \_\_\_\_\_

Phone \_\_\_\_\_  
Fax \_\_\_\_\_

Have you ever seen a Psychologist/Counselor?

Yes No

If yes, please list provider \_\_\_\_\_  
Address/City/State \_\_\_\_\_

Phone \_\_\_\_\_  
Fax \_\_\_\_\_

Have you ever taken medications for psychiatric problems or for depression?

Yes No

If yes, please list medication, side effects and duration \_\_\_\_\_

Have you ever been in a chemical dependency program?

Yes No

Have you ever been physically abused?

Yes No

**FOR WOMEN ONLY**

**Gynecologic**

Problems conceiving (infertility)  
Are you pregnant?  
Uterine/Ovarian Cancer?  
Hysterectomy  
Menstrual irregularity  
Menstrual pain  
Are you post menopausal?

Yes No  
Yes No  
Yes No  
Yes No  
Yes No  
Yes No  
Yes No

Are you pregnant or could you be?  
Are you using Birth Control?  
What type? \_\_\_\_\_

Yes No  
Yes No

Do you have excessively, heavy periods?  
Do you plan to have more children?  
Do you have PCOS (Polycystic ovaries)

Yes No  
Yes No  
Yes No

Date of menopausal onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last pap smear: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age started menses: \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_

How many children have you had? \_\_\_\_\_

**Breast**

Lumps  
Nipple discharge  
Breast Implants

Yes No  
Yes No  
Yes No

How many miscarriages or abortions have you had? \_\_\_\_\_

## SOCIAL HISTORY

**Tobacco Use** Have you ever smoked?

Yes  No

Do you smoke now?

Yes  No

Have you smoked Cigarettes in the past year?

Yes  No

If yes, how many cigarettes and/or packs per day? \_\_\_\_\_

How long ago did you quit? \_\_\_\_\_  Weeks  Months  Years

Do you use smokeless/vapor cigarettes?  Yes  No Do you use snuff or chew?  Yes  No

If yes, how frequently do you use smokeless cigarettes/snuff/chew? \_\_\_\_\_

**Alcohol Use** Have you ever consumed alcohol?

Yes  No

Do you consume alcohol now?

Yes  No

If yes, how many times a week? \_\_\_\_\_

If yes, how many drinks per day? \_\_\_\_\_

For how many years do/did you drink alcohol? \_\_\_\_\_

If you quit how long ago? \_\_\_\_\_ Weeks Months Years (please circle one)

Is anyone concerned about the amount you drink?  Yes  No

**Drug Use** Have you ever done street drugs?

Yes  No

Do you use street drugs now?

Yes  No

If yes, which drugs? \_\_\_\_\_

If yes, how frequently do you use these drugs? \_\_\_\_\_

If you quit how long ago? \_\_\_\_\_ Weeks Months Years (please circle one)

### Caffeine Use

Do you drink coffee or other caffeine-containing beverages?  Yes  No

If yes, how many cups per day? \_\_\_\_\_ cups Other \_\_\_\_\_

Do you drink carbonated beverages?  Yes  No

If yes, how many? \_\_\_\_\_ cans Other \_\_\_\_\_

### Lifestyle:

Please rate the following situations in your life on a scale of 1 to 5: (1=least satisfied; 5=very satisfied)

Single  Married  Divorced  1  2  3  4  5

Present job?  1  2  3  4  5

Overall satisfaction with yourself?  1  2  3  4  5

Comments \_\_\_\_\_

## WEIGHT HISTORY SECTION

**Unsupervised diet attempts that you did on your own.** (Check all that apply and enter the weight lost, weight regained, duration of time spent following the diet and number of attempts)

No unsupervised diet attempts of any kind.

Diet	Please use Month/Year	From	- To	Lost	Regain	# of Attempts
<input type="checkbox"/> High Protein Low Carb		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Low Fat		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Calorie Counting		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Slim Fast		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Other 1: _____		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Other 2: _____		_____	_____	_____ lbs.	_____ lbs.	_____

**Supervised Diet Attempts** (Check all that apply and enter the weight lost, regained, duration of time spent following the diet and number of attempts)

Diet	Please use Month/Year	From	- To	Lost	Regain	# of Attempts
<input type="checkbox"/> Physician Supervised		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Nutri-Systems		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Optifast		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Weight Watchers		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Jenny Craig		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Other 1: _____		_____	_____	_____ lbs.	_____ lbs.	_____
<input type="checkbox"/> Other 2: _____		_____	_____	_____ lbs.	_____ lbs.	_____

**Medications Prescribed for Weight Loss** (Medications may be listed both as generic and name brand. Check medications that you have taken for weight loss.)

No Weight Loss medications.

**Medication**

Dexatrim     Phentermine     PhenDiet    Other: \_\_\_\_\_

Did these medications work for you?     Yes     No

**Behavioral Treatments for Weight Loss** (Please check all behavioral treatments that you have had while attempting to lose weight)

No behavioral treatments

Treatment	Lost	Regained	Duration
<input type="checkbox"/> Hypnosis	_____ lbs.	_____ lbs.	_____ mo.
<input type="checkbox"/> Hospitalization	_____ lbs.	_____ lbs.	_____ mo.
<input type="checkbox"/> Psychologist Therapy	_____ lbs.	_____ lbs.	_____ mo.
<input type="checkbox"/> Residential Programs	_____ lbs.	_____ lbs.	_____ mo.

What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ in.      How much do you weigh? \_\_\_\_\_ lbs.

What was your weight at the following ages? (Please estimate/use approximate weight if you do not know exactly)

At Age 10 what did you weigh? \_\_\_\_\_

At Age 30 what did you weigh? \_\_\_\_\_

At Age 18 what did you weigh? \_\_\_\_\_

At Age 35 what did you weigh? \_\_\_\_\_

At Age 25 what did you weigh? \_\_\_\_\_

At Age 40 what did you weigh? \_\_\_\_\_



At Age 45 what did you weigh? \_\_\_\_\_

At Age 60 what did you weigh? \_\_\_\_\_

At Age 50 what did you weigh? \_\_\_\_\_

At Age 65 what did you weigh? \_\_\_\_\_

1. Eating Habits: (check all that apply)

Scheduled meal eater

No set schedule

Binge eating/compulsive eater

Emotional eater

Night eater

Other \_\_\_\_\_

Rapid eater

Junk food eater

Meat and potatoes type

Sweet eater

Fast food eater

Large/multiple servings

2. Do you plan meals in advance?  Yes  No

3. Do you have food cravings?  Yes  No

4. Do you eat more rapidly than other people do?  Yes  No

5. Are there episodes in which you eat an unusually large amount of food in a relatively short amount of time?  Yes  No

6. Do you often eat until you are uncomfortably full?  Yes  No

7. Can you tell when you have had enough to eat?  Yes  No

8. Do you often eat large portions even when you don't feel physically hungry?  Yes  No

9. How many times a week do you overeat? \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

10. Do you eat while:

Watching TV/On Computer?  Yes  No

In bed?  Yes  No

In car?  Yes  No

11. How many meals do you eat daily? \_\_\_1 \_\_\_2 \_\_\_3

\_\_\_4 \_\_\_5 \_\_\_more

12. What time of the day is your largest meal? \_\_\_\_\_

13. Are most of your daily calories consumed in the evening/night?  Yes  No

14. Do you often skip meals and then overeat later?  Yes  No

15. How many times each week do you eat fast food? \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

16. How many times per week do you dine out? \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

17. How many times per week do you eat fried food? \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

18. How many times per week do you eat sweets (cookies, cake, ice cream, chocolate, etc)?

\_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

19. How many times per week do you eat food such as chips, pretzels, crackers or other prepackaged snack items? \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

20. Do you drink beverages with calories such as soda, juice, fruit drinks, milk?

\_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_more

21. Do you have food allergies?  Yes  No Intolerances?  Yes  No

If you answered "yes", what foods are you allergic/intolerant to? \_\_\_\_\_

22. Activity: (check one)

Restricted (Wheel Chair or Bed Bound)

Sedentary (activities of daily living including working, light housework, etc)

Low active (90-120 minutes each week or more of scheduled exercise with increased heart rate)

- Active (120-150 minutes each week or more of scheduled exercise with increased heart rate)
- Very active training (150-180 minutes or more of scheduled exercise with increased heart rate)

Please explain your current activity \_\_\_\_\_

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**23. Weight History:**

From what age have you been overweight/obese? Age \_\_\_\_\_

For how many years have you been at your current weight? \_\_\_\_\_ years

What was your maximum adult weight? \_\_\_\_\_ lbs. What was your minimum adult weight? \_\_\_\_\_ lbs.

**24. Have you used any of the following to control your weight? (If YES, When?)**

Bingeing and purging?  Yes  No When \_\_\_\_\_

Bingeing followed by food restriction?  Yes  No When? \_\_\_\_\_

Laxatives  Yes  No When \_\_\_\_\_

Diuretics  Yes  No When \_\_\_\_\_

Vomiting  Yes  No When \_\_\_\_\_

**25. Why do you eat? (check one or more)**

- Physical hunger
- Sight and/or smell of food
- Other \_\_\_\_\_
- Out of emotion
- Boredom

**26. What reasons do you feel contribute to you being overweight? (check all that apply)**

- Inactivity
- Emotional well-being
- Over consumption
- Eating too fast
- Medications
- Skipping meals and then overeating
- Eating oversized portions
- Eating when bored
- I always clean my plate
- Grazing / snacking
- Too many sweets / starches
- Eating on the run
- Eating as a self reward
- Eating for comfort
- Can't tell when you have eaten enough
- Other: \_\_\_\_\_

**27. Motivation and Support**

How important is that you lose weight at this time? (check one)

- Not important
- Somewhat important
- Very important

**28. Why do you want to lose weight? Please explain:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**29. Is your decision to lose weight for you or for someone else?  Self  Someone Else**

**30. Who is your primary support person other than yourself? \_\_\_\_\_**

**31. Are they supportive of your decision to have weight loss surgery?  Yes  No**

**32. How do you think weight loss will affect your life? (please explain) \_\_\_\_\_**

\_\_\_\_\_  
 \_\_\_\_\_

**33. What behaviors will you need to change? \_\_\_\_\_**

**34. Weight Loss Goals and Expectations**

-How much weight do you expect/hope to lose? \_\_\_\_\_

-How fast do you expect to lose weight? \_\_\_\_\_

-What goals would you like to set for yourself? \_\_\_\_\_

35. Additional Comments

**SLEEP APNEA QUESTIONS**

Have you ever been diagnosed with sleep apnea? \_\_\_Yes \_\_\_No

If you answered yes, when was your last appointment with sleep medicine?

\_\_\_Less than 1 year \_\_\_Over a year \_\_\_Don't remember \_\_\_Other

Do you have a CPAP machine? \_\_\_Yes \_\_\_No

If you answered yes, what is your setting? \_\_\_\_\_

If you have not been diagnosed with sleep apnea, please answer the "STOP-Bang" questions below.

**Sleep Apnea Screening Tool: STOP-Bang**

Gender? \_\_\_Male \_\_\_Female

- 1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? \_\_\_Yes \_\_\_No
- 2. Do you often feel tired, fatigued or sleepy during the daytime? \_\_\_Yes \_\_\_No
- 3. Has anyone observed you stop breathing during your sleep? \_\_\_Yes \_\_\_No
- 4. Do you have or are you being treated for high blood pressure? \_\_\_Yes \_\_\_No
- 5. BMI greater than 35 kg/m<sup>2</sup>? \_\_\_Yes \_\_\_No
- 6. Are you over 50 years old? \_\_\_Yes \_\_\_No
- 7. Is your neck circumference greater than 16 inches? \_\_\_Yes \_\_\_No

Is there any additional information or comments you would like to share? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*By signing above, you agree that all information provided is accurate to the best of your knowledge.*

The Patient's History and Information Form has been Reviewed by:

Provider:  
Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Dietitian:  
Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Psych:  
Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

