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____________________________

____

____

____

Medication Information It is important that we know what medications you are currently taking. Please help us by providing, accurate, detailed information. This includes vitamins, mineral and herbal supplements (please provide over the counter as well as natural or herbal medications. Example: multi-vitamin, iron, vit C, etc.). If you need more space to list medications, please go to back page of your packet.

Allergies – Foods and/or medicines: Please list any allergies____

____

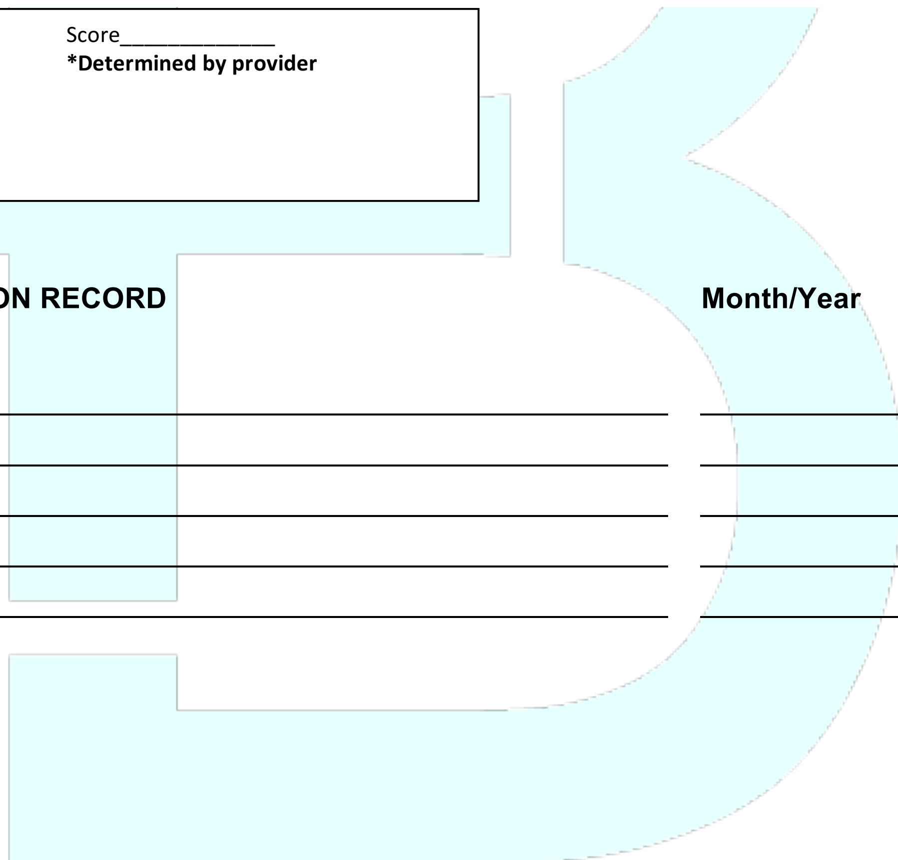
Medication	Dose	Frequency

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				
* PHQ-9 ©Copyright 1999 Pfizer **Totals**				

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



SURGICAL/HOSPITALIZATION RECORD **Month/Year**

List of Surgeries/Date/Year

Surgery Performed____ ____________________

Surgery Performed____ ____________________

Surgery Performed____ ____________________

Surgery Performed____ ____________________

Surgery Performed____ ____________________

REVIEW OF SYSTEMS

Bladder/Kidney

Kidney Stones	○Yes	○No
Frequent UTIs	○Yes	○No
Loss of bladder control (leakage)	○Yes	○No
Kidney Insuffiency	○Yes	○No
Kidney Failure	○Yes	○No
Dialysis	○Yes	○No
For Men: PSA test in the last year	○Yes	○No
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
Hypoventilation 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 ○Yes ○No
Sciatica ○Yes ○No
Muscle pain spasm ○Yes ○No
Broken bones ○Yes ○No
Nerve injury ○Yes ○No
Muscular dystrophy ○Yes ○No

Neurologic

Balance disturbance ○Yes ○No
Seizure or convulsions ○Yes ○No
Weakness ○Yes ○No

Stroke ○Yes ○No
Alzheimer's ○Yes ○No
Loss of vision from pressure in the brain ○Yes ○No
Multiple Sclerosis ○Yes ○No
Frequency severe headaches/migraines ○Yes ○No

Skin

Rashes under skin folds ○Yes ○No
Frequent skin infections ○Yes ○No
Keloids (excessively raised scars) ○Yes ○No
Poor wound healing ○Yes ○No

Psychiatric

Anxiety ○Yes ○No
Depression ○Yes ○No
Anorexia (starvation to control weight) ○Yes ○No
Bulimia (excessive vomiting to control weight) ○Yes ○No
Bipolar disorder ("manic-depression") ○Yes ○No

Alcoholism ○Yes ○No
Drug dependency ○Yes ○No
Schizophrenia ○Yes ○No
Other psychiatric problems ○Yes ○No
Have you ever attempted suicide? ○Yes ○No

Have you ever been sexually abused? ○Yes ○No

Have you ever been in a psychiatric hospital? ○Yes ○No
f yes, please list facility ______________________________ Phone ______________
Address/City/State Fax

Have you ever seen a psychiatrist? ○Yes ○No
f yes, please list provider ______________________________ Phone ______________
Address/City/State Fax

Have you ever seen a Psychologist/Counselor? ○Yes ○No
f yes, please list provider ______________________________ Phone ______________
Address/City/State Fax

Have you ever taken medications for psychiatric problems or for depression? ○Yes ○No
f 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) ○Yes ○No
Are you pregnant? ○Yes ○No
Uterine/Ovarian Cancer? ○Yes ○No
Hysterectomy ○Yes ○No
Menstrual irregularity ○Yes ○No
Menstrual pain ○Yes ○No
Are you post menopausal? ○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?_____________

Are you pregnant or could you be? ○Yes ○No
Are you using Birth Control? ○Yes ○No
What type?______________________________
Do you have excessively, heavy periods? ○Yes ○No
Do you plan to have more children? ○Yes ○No
Do you have PCOS (Polysystic ovaries) ○Yes ○No

Breast

Lumps ○Yes ○No
Nipple discharge ○Yes ○No
Breast Implants ○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**
○ High Protein Low Carb	________	_______	________lbs.	_______lbs.	________
○ Low Fat	________	_______	________lbs.	_______lbs.	________
○ Calorie Counting	________	_______	________lbs.	_______lbs.	________
○ Slim Fast	________	_______	________lbs.	_______lbs.	________
○ Other 1:_____________	________	_______	________lbs.	_______lbs.	________
○ 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**
○ Physician Supervised	________	_______	________lbs.	_______lbs.	________
○ Nutri-Systems	________	_______	________lbs.	_______lbs.	________
○ Optifast	________	_______	________lbs.	_______lbs.	________
○ Weight Watchers	________	_______	________lbs.	_______lbs.	________
○ Jenny Craig	________	_______	________lbs.	_______lbs.	________
○ Other 1:_____________	________	_______	________lbs.	_______lbs.	________
○ 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**
○ Hypnosis	_______lbs.	_______lbs.	________mo.
○ Hospitalization	_______lbs.	_______lbs.	________mo.
○ Psychologist Therapy	_______lbs.	_______lbs.	________mo.
○ 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 18 what did you weigh? _____

At Age 25 what did you weigh? _____

At Age 30 what did you weigh? _____

At Age 35 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 Intollerances? ○Yes ○No

If you answered “yes”, what foods are you allergic/intollerant 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____
____

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/m2? ___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______________