PATIENT INFORMATION PACKET

Name __________________________________________ Date ______________________
E-mail __________________________________________ Phone (______) __________________

PRIMARY CARE PHYSICIAN: ________________________________
CARDIOLOGIST: ________________________________________ PULMONOLOGIST: ________________________________

Please list any other doctors you regularly visit:
____________________________________ Specialty: __________________________
____________________________________ Specialty: __________________________
____________________________________ Specialty: __________________________

PERSONAL & FAMILY HISTORY: If you and/or any blood relative have suffered any of the following, please mark and indicate relationship.

☐ Anemia ______________________ ☐ Gout ______________________
☐ Asthma ______________________ ☐ Heart Disease ______________________
☐ Bleeding ______________________ ☐ High Cholesterol ______________________
☐ Blood clots ______________________ ☐ Hypertension ______________________
☐ Cancer ______________________ ☐ Kidney Disease ______________________
☐ Diabetes ______________________ ☐ Migraine ______________________
☐ Epilepsy ______________________ ☐ Obesity ______________________
☐ Gallstones ______________________ ☐ Sleep apnea ______________________
☐ Glaucoma ______________________ ☐ Stroke ______________________
☐ Scleroderma ______________________ ☐ Lupus ______________________

Other Auto Immune disorders: ______________________________________________________________________________________________

SOCIAL HISTORY:

☐ Are/where you a smoker? ☐ Yes ☐ No For how long? __________ Packs/day: __________
☐ Have you quit smoking? ☐ Yes ☐ No How long ago? ______________________
☐ Consume alcohol ☐ Yes ☐ No Drinks/day? ______________________
☐ Use recreational drugs? ☐ Yes ☐ No Type/frequency? ______________________

How is your health in general? ☐ Good ☐ Fair ☐ Poor
**PLEASE LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC:**

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<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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**LIST ANY MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS YOU ARE PRESENTLY TAKING:** *(Continue on back)*

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Time taken</th>
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**REVIEW OF SYSTEMS:**

**HEENT**

- Decreased hearing
- Ringing in Ear
- Ear Infections (frequent)
- Dizzy Spells
- Fainting Spells
- Eye Infections (frequent)
- Eye Pain
- Failing Vision
- Double/Blurred Vision
- Nose Bleeds (recurrent)
- Sinus Trouble
- Sore Throat (frequent)
- Hay Fever/Allergies

**PULMONARY**

- Lung problems
- Pneumonia/Pleurisy
- Sleep apnea
- Shortness of Breath
- Does your family say you have loud and/or irregular snoring? ✓ Yes ❌ No
- Do you use CPAP? ☐ on exertion ☐ lying flat
- Bronchitis
- Hyperventilation syndrome

**GASTROENTEROLOGY**

- Loss of appetite (recent)
- Gallbladder
- Constipation
- Bloody/Tarry Stools
- Ulcer
- Heartburn
- Take antacids or medication? ✓ Yes ❌ No
- For how many years? ____________
- GERD
- Take medication for GERD ✓ Yes ❌ No
- For how many years? ____________
- Had upper gastrointestinal (UGI) endoscopy? ✓ Yes ❌ No
- When? ________________
- Abdominal pain (chronic)
- Difficulty swallowing
- Hernia
- Diarrhea
- Diverticulitis
- Jaundice/Hepatitis
- Change in bowel habits
- Hemorrhoids
- Crohn's/Colitis

**GENITOURINARY**

- Kidney problems
- Painful urination
- Venereal disease
- Infertility
- Is there a diagnosis? ________________________
- Urinary Infections (frequent)
- Urethral discharge
- Decrease in force/flow
- Blood in urine
- Urination overnight
- Urinary stress incontinence

**Males:** ☐ Prostate enlargement

**Females:** ☐ Date of last menstrual period: ____________ Are your periods Regular ✓ Yes ❌ No
- Are you using birth control? ✓ Yes ❌ No
- If yes, what type? ________________________
- Number of pregnancies: ____________
- Number of live births: ____________
- Menopause
### CARDIOVASCULAR

- **High Blood Pressure (Hypertension)**
  - Yes
  - No
  - For how many years? ___________

- **Heart disease**
  - Describe: __________________________________________________________

- **Heart Murmur**
  - Palpitations
  - Irregular Pulse

- **Varicose Veins/Phlebitis**
  - Swollen Ankles
  - Leg Pain (when walking)

### NEUROLOGY/PSYCHIATRY

- **Seizures**
  - Muscle weakness

- **Stroke**
  - Numbness/Tingling

- **Tremors/Hands shaking**
  - Nervousness

- **Memory loss**
  - Mental illness
  - Describe: __________________________________________________________

- **Suicidal**
  - Depression
  - Hospitalized for depression
  - Yes
  - No

### HEMATOLOGY/ONCOLOGY

- **Anemia (low hemoglobin)**
  - Abnormal bleeding or clotting

- **Cancer or other tumor?**
  - Yes
  - No
  - Specify: ___________________________________________________________

- **HIV Positive?**
  - Yes
  - No

### ENDOCRINOLOGY/METABOLIC

- **Elevated Cholesterol**

- **Do you have Diabetes?**
  - Yes
  - No
  - When were you diagnosed? ________________________________

### DERMATOLOGY

- **Rashes**

- **Hives**

- **Psoriasis**

- **Eczema**

### MUSCULOSKELETAL

- **Lower leg ulcers**

- **Osteoporosis**

- **Gout**

- **Do you have bone, joint or muscle problems?**
  - Yes
  - No
  - Diagnosis: _______________________________________________________

- **Spine**

- **Hip**

- **Knee**

- **Ankle**

- **Other:** ________________________________________________

### MISCELLANEOUS

- **Measles**

- **Mumps**

- **Chicken Pox**

- **Herpes**

- **Rheumatic Fever**

- **Scarlet Fever**

- **Tuberculosis**

### SURGERY:

- **Have you had surgery on your abdomen?**
  - Yes
  - No

- **Removal of gall bladder**
  - Open or Laparoscopic
  - Date: ________________

- **Hysterectomy (removal of uterus)**
  - Date: ________________

- **Appendectomy**
  - Date: ________________

Please list any other procedures you might have had, including dates and Hospitals.

________________________________________________________________________________________
WEIGHT LOSS HISTORY:

Please check the appropriate boxes and add notes as needed (be as specific as possible).

My obesity started: ☐ in childhood ☐ at puberty ☐ as an adult
☐ after pregnancy ☐ after a traumatic event

Additional notes regarding the onset of obesity:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Height: ______________________________ Weight ______________________________

Highest adult weight: __________________________ at age: __________________________

Lowest adult weight: __________________________ at age: __________________________

Most weight lost on any program: __________________________ Program and year: __________________________

How long did it take you to lose weight? __________________________

Did you gain any back? __________________________ After how long? __________________________

At what weight have you felt your best or do you think you would feel your best? __________________________

Why are you seeking bariatric surgery at this time? __________________________

Why do you think success is possible this time? __________________________

Surgery preference: ☐ Lap-Band ☐ Bypass ☐ Sleeve

What are the attitudes of the following people about your attempt(s) to lose weight?

Spouse: ☐ Positive ☐ Indifferent ☐ Negative
Children: ☐ Positive ☐ Indifferent ☐ Negative
Parents: ☐ Positive ☐ Indifferent ☐ Negative
Friends: ☐ Positive ☐ Indifferent ☐ Negative
Co-workers: ☐ Positive ☐ Indifferent ☐ Negative

Do these attitudes affect your weight loss or gain? ☐ Yes ☐ No

If yes, please describe: ________________________________________________________________

Have you ever: ☐ Yes ☐ No

Induced vomiting __________________________

Binge eaten (eat uncontrollably) __________________________

Taken laxatives __________________________

Do you take vitamin, mineral or nutritional supplements? ☐ Yes ☐ No

____________________________________________________________________________________________

TASTE PREFERENCES (please check all that apply)

☐ Sweets ☐ Salty ☐ Fast Food ☐ Comfort food: __________________________

EATING HABITS (please check all that apply)

☐ Stress ☐ Boredom ☐ Loneliness ☐ Other: __________________________

How fast do you normally eat? ☐ Quickly ☐ Fast ☐ Moderately

Do you chew your food thoroughly? ☐ Yes ☐ No ☐ Sometimes
Please list food allergies: ____________________________________________

Do you have any food intolerances or special diet needs that you follow now?  □ Yes  □ No

If yes, please list: ____________________________________________

Are there foods that you dislike and refuse to eat? ________________________________

What are your favorite foods? ____________________________________________

Circle equipment do you already have?  □ Blender  □ Food processor  □ Fine sieve  □ Measuring cups

Have you read about food and beverage guidelines you will need to follow after surgery?  □ Yes  □ No

Do you know how to make smooth, blenderized foods?  □ Yes  □ No

Do you understand how to read food labels?  □ Yes  □ No

Do you understand the consequences of not complying with the food guidelines after surgery?  □ Yes  □ No

Do you understand the long-term changes in food intake that will be necessary for all occasions after surgery for the rest of your life?  □ Yes  □ No

Do you know if you are eating or drinking for reasons other than hunger or thirst  □ Yes  □ No

Can you tell when you are physically satisfied with the amount of food you have eaten?  □ Yes  □ No

Can you tell when your stomach is “full”?  □ Yes  □ No

Can you tell when your stomach is “stuffed”?  □ Yes  □ No

Do you like to drink water?  □ Yes  □ No

WOMEN ONLY:
History of infertility: ____________________________________________

Plans to become pregnant: ____________________________________________

WEIGHT LOSS PROGRAMS, DIETS AND/OR MEDICATIONS: (please check all that apply)

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<th>Dates (From - To)</th>
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<th>End Weight</th>
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<td>Other – self implied diets</td>
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<td>Quick program</td>
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<td>Redux</td>
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</table>
Medical weight management programs:

[ ] Additional Physician or Hospital supervised weight loss program:

**PLEASE TRY TO RECALL YOUR LAST 24 HOUR INTAKE: (typical day)**

| BREAKFAST: | _______________________________________________________________________________ |
| LUNCH: | _______________________________________________________________________________ |
| DINNER: | _______________________________________________________________________________ |
| SNACKS: (include all sweets & salty, any in between meal eating) | A.M. ____________________________________________________________________________ | P.M. __________________________________________________________________________ |
| ANY BINGES OR OVERNIGHT EATING (if so why)? | _______________________________________________________________________________ |
| HIGH CALORIE LIQUIDS INCLUDING SODA & ALCOHOL: | _______________________________________________________________________________ |
| FRIED/FAST FOODS/PIZZA: | _______________________________________________________________________________ |

**PLEASE GRADE HOW OBESITY HAS LIMITED EACH LIFE COMPONENT: (1=minimal, 5=severely affects)**

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Please tell us anything else that you would like us to know to help us provide you with the best possible care:

______________________________________________________________________________________

**LIVE without the weight**