

PRE-OPERATIVE PATIENT CARE
WEIGHT LOSS HISTORY

PATIENT INFORMATION

Approximate age when you first seriously tried to lose weight: _____

List all of the diets/weight loss efforts **you have tried.**

Program	Start and End dates and/or	Duration	Amount Loss
Jenny Craig			
Nutri-Systems			
Weight Watchers			
Opti/Medi Fast			
T.O.P.S.			
O.A.			
Acupuncture			
Atkins			
Grapefruit Diet			
Cabbage Soup diet			
South Beach			
Low Fat			
Low Calorie			
Slim Fast			
Dexatrim			
Exercise: name type			
Other			
other			

List any physician-directed weight loss attempts: Please indicate what diet and/or exercise was included

	Dr.'s Name and city	year and length of treatment	weight lost
Fen/Phen			
Phentermine			
Meridia			
Lindora			
Xenical			
Byetta			

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet). Rank each selection from 1- like very much to 4 – don't care

- | | | | |
|-------------------------|--------------------|-----------------------|-------------------|
| _____ soda/ soft drinks | _____ French fries | _____ chips/snacks | |
| _____ steaks/chops | _____ candy | _____ potatoes | |
| _____ chocolate | _____ pasta | _____ cookies | |
| _____ pizza | _____ cakes/pies | _____ salad dressings | _____ fried foods |

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

Problem	Yes	NO	Medications include over counter	dosage	frequency	When diagnosed
<i>GERD</i>						
<i>Gallstone Disease</i>						
<i>Renal Insufficiency</i>						
<i>Renal Failure req dialysis</i>						
<i>Myocardial Infarction/(heart attack)</i>						
<i>Previous PCI</i>						
<i>Angina</i>						
<i>Coronary Artery Bypass</i>						
<i>Heart Palpitations</i>						
<i>Hyperlipidemia; High Cholesterol High Triglycerides</i>						
<i>High Blood Pressure</i>			<i>List all meds for this:</i>			
<i>Blood clots</i>						
<i>Venous Stasis Phlebitis</i>						
<i>Diabetes</i>						
<i>Neuropathy</i>						

PRE-OPERATIVE PATIENT CARE			PATIENT INFORMATION			
Problem	Yes	NO	Medications include over counter	dosage	frequency	When diagnosed
Depression						
Other mental disorder						
Heartburn						
Hiatal Hernia						
Esophagitis						
RefluNA						
Belching sour liquid			NA	NA	NA	
Choking at night			NA	NANA	NA	NA
Asthma						
Shortness of Breath			NA	NA	NA	NA
Obesity Hyperventilation Syndrome						
How many flights of stairs can you climb	NA	NA	Number:	NA	NA	NA
How long or far can you walk Before needing to stop	NA	NA	Time: Distance:	NA	NA	NA
Low Back Pain						
Pain in hips						
Pain in ankles						
Swelling of feet or legs						
Activity limited by pain			ENApain:	NA	NA	NA
Are any surgeries planned for joint problems			Which joint:	NA	NA	NA
Thyroid problem						
SLEEP APNEA			C-Pap Y N			
If yes, skip *			BiPap Y N			
*Daytime drowsiness			NA	NA	NA	NA
*Restless Sleep			NA	NA	NA	NA
*Frequently aroused from sleep			NA	NA	NA	NA

PRE-OPERATIVE PATIENT CARE			PATIENT INFORMATION			
*snoring			NA	NA	NA	NA
*Trouble initiating sleep			NA	NA	NA	NA
*Trouble maintaining sleep			NA	NA	NA	NA
*Morning headaches			NA	NA	NA	NA
*Drowsiness during the day			NA	NA	NA	NA
Have you smoked within the last yr			When did you stop?			
			How much a day?	NA	NA	NA
Do you require Oxygen?			When/how often:			NA
Pulmonary Embolism			When:	NA	NA	NA
Other Blood Clot				NA	NA	NA
Severe COPD						
Has your gallbladder been removed?			When:	NA	NA	NA
Any weight related injuries?			ENApain:			

Please identify which of the following childhood illnesses and operations you have eNAperieneced:

- | | |
|---------------------------------------|--|
| <input type="radio"/> rheumatic fever | <input type="radio"/> heart murmur |
| age _____ | <input type="radio"/> bleeding disorders |
| year _____ | |
| <input type="radio"/> appendectomy | <input type="radio"/> tonsillectomy |
| age _____ | age _____ |
| year _____ | year _____ |

Please list below all serious illnesses and hospitalizations you have eNAperieneced in adulthood:

SURGERIES	Date	Open or laparoscopic
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER ILLNESSES/ PROBLEMS

Date

Allergic to any medications:

Yes No If yes, list medication **and** reaction:

Allergic to surgical tape/latex:

Yes No describe reaction: _____

Do you use tobacco? yes no Amt/Frequency: _____

Do you use alcohol? yes no Amt/Frequency: _____

Please list below any medications, vitamins or supplements you take that you have not already listed

Medication	Dose and Frequency	What is it for/Why do you take

FAMILY HISTORY

Family Member	Living?	Age	Deceased at age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling				
Sibling				
Sibling				
Sibling				

Please indicate if there is a family history of:

- obesity
- diabetes
- high blood pressure
- heart disease
- high blood cholesterol
- lung disease, asthma or emphysema
- kidney disease
- bleeding tendency or blood disorder
- breast cancer
- colon cancer

**Please list all the physicians whose care you under or have been under in the past 5 years : BE COMPLETE
PLEASE PROVIDE THE PHONE NUMBER TO ASSIST US SERVING YOU TIMELY**

	Name	Telephone
Primary Care Physician	_____	
Internist	_____	
Gynecologist	_____	
Orthopedist	_____	
Psychiatrist	_____	
Psychologist	_____	
Therapist	_____	
Other /Additional:	_____	

SYSTEM REVIEW: *Circle all symptoms which you have, or have had. Write in any additional problems.*

HEAD, EYE, EAR, NOSE & THROAT

- | | | | |
|----------------------|----------------------|-----------------|--------------------|
| Stuffy Nose | Runny Nose | Hay Fever | Sinus Trouble |
| Earache | Headache | Blurry Vision | Double Vision |
| Haloed around lights | Loss of Night Vision | Buzzing in Ears | Ringing in Ears |
| Discharge from Ear | Loss of Hearing | Dizziness | Vertigo |
| Loss of Balance | Sore Throat | Lump in Throat | Trouble Swallowing |
| Pain w/Swallowing | Hoarseness | | |

RESPIRATORY

- | | | |
|---------------|-----------------|--------------------------------------|
| Cough | Wheezing | Shortness of Breath at Night |
| Use 2 Pillows | Blood in Sputum | Out of Breath with Exertion |
| Asthma | Emphysema | Wake up at Night Short of Breath |
| Bronchitis | | Wake up at Night Coughing or Choking |

CARDIOVASCULAR

- | | | | |
|----------------|---------------------|---------------------|----------------------------|
| Palpitations | Pounding of Heart | Pains in Chest | Skipping of Heartbeat |
| Pains in Neck | Pains in Arms | Squeezing of Chest | Heart Attack |
| Heart Murmur | Irregular Heartbeat | High Blood Pressure | Abnormal Electrocardiogram |
| Pain in Legs | Cold Feet | Blue Toes | Blue Finger |
| Loss of Pulses | | | |

GASTROINTESTINAL

Nausea	Vomiting	Burning in Throat	Pains in Stomach	Burning in Stomach
Acid Stomach	Diarrhea	Constipation	Pain with Bowel Movement	
Blood in Stools	Hemorrhoids	Fissures	Cramps	
Gassiness	Irritable Colon	Colitis		

ENDOCRINE (GLANDULAR)

Goiter	Grave's Disease	Thyroid Nodules	NA-ray to Thyroid
Frequent Flushing	Frequent Heavy Sweating		

MUSCULOSKELETAL

Swelling of Joints	Warm Joints	Redness of Skin over Joints	
Fluid in Joints	Broken Bones	Sprains	
Foot Pain	Flat Feet	Slipped Disk	Herniated Disk
Sciatica			

NEUROLOGICAL

Dizziness	Vertigo	Falling to the Side	Falling at Night
Numbness	Tingling	Shakiness	Pins & Needles Feelings
Twitching of Muscles	Weakness of Grip	Tremor	Weakness of any Muscle
Fainting	Convulsions	Fits	Loss of Consciousness

PSYCHOLOGICAL

Nervousness	Anxiety		
Thoughts of Suicide	Suicide Attempts	Hospitalizations for Emotional Problems	
Psychiatric Treatment	Psychological Counseling		

FOR FEMALE PATIENTS ONLY:

Do you presently use:

Birth Control pills ___yes ___no

Birth Control patch ___yes ___no Birth control injections ___yes ___no

Estrogen/Progesterone ___yes ___no

Please list type of birth control you use, if not listed above: _____

Do you have leakage of urine when coughing/laughing/sneezing ___yes ___no