PATIENT PROFILE

Patient Name: _____ **Age:** _____

Date of Birth: _____ **Sex**: __ Male__ Female **Height**: _____ **Weight**: _____ **BMI**: ____
Heaviest adult weight? _____ Lowest adult weight? _____ At what age did you first notice you had a weight problem? _____

MEDICAL HISTORY/ REVIEW OF SYSTEMS: → **Please check ALL that apply OR Check NONE**

Cardiovascular: □ **None**
□ A-Fib □ Heart Disease
□ Heart Attack □ High Blood Pressure
□ Increased Cholesterol □ PVD
□ Valvular Disease □ Stent
□ Pacemaker, Date placed_____
□ Other _____
Cardiologist name: _____

Neuro: □ **None**
□ Stroke □ TIA □ MS
□ Numbness □ Weakness
□ Headaches □ Dizziness
□ Seizures □ Dementia
□ Cerebrovascular Disease
□ Other _____
Neurologist Name:
_____

Gastrointestinal: □ **None**
□ Ulcers □ Abdominal Pain
□ Nausea □ Vomiting
□ Constipation □ Diarrhea
□ Bloody Stools □ C-Diff
□ Previous Stomach Surgery
□ GERD
□ Other _____
Gastro Dr. name:
_____

Hema/Lymph: □ **None**
□ Clotting Disorder □ Anemia □ AIDS
□ Bleeding Disorder □ HIV
□ Cancer, Type:_____
□ Other _____
Hematologist name: _____
Oncologist name: _____

Respiratory: □ **None**
□ Difficulty Breathing □ Coughing
□ Shortness of Breath □ Asthma
□ Sleep Apnea □ COPD
□ CPAP Use □ Pulm. Embolism
□ Other: _____
Pulmonologist name:_____

Genitourinary: □ **None**
□ Kidney Disease
□ Urinary Frequency
□ Discomfort Urinating
□ Other _____
□ Dialysis use- Days: _____
Dialysis Location: _____

Integumentary: □ **None**
□ Skin Rashes □ MRSA
□ Skin Ulcers
□ Autoimmune Disease
□ Other _____
Dermatologist name:
_____

ENT/Mouth: □ **None**
□ Hearing Problems
□ Dentures □ Missing Teeth
□ Difficulty Swallowing
□ Other _____

Endocrine: □ **None**
□ Liver Problems □ Thyroid Problem
□ Hepatitis Type _____
□ Diabetes Type _____
□ Other _____
Endocrinologist name:_____

Constitutional: □ **None**
□ Fevers □ Weight Loss
□ Fatigue □ Weight Gain
□ Night Sweats □ Other _____

Eyes: □ **None**
□ Glaucoma □ Cataracts
□ Visual Disturbances
□ Other _____

Musculoskeletal: □ **None**
□ Difficulty Walking
□ Arthritis, location:_____
□ Gout □ Knee pain
□ Other _____

Allergy/Immune: □ **None**
□ Season Allergies □ Latex Allergy
□ Medicine Allergies □ Tape/Adhesive
□ Iodine □ Shellfish
□ Food Allergy (List) _____

Psych: □ **None**
□ Depression □ Anxiety
□ Bipolar
□ Other _____

Social History:
Smoke: ☐ Yes ☐ No ☐Never Smoker
Pack(s)/Day _____ WKs_____ Years ____
☐ Current Smoker ☐ Former Smoker
☐ Cigarettes ☐ Cigars
Alcohol: ☐ Yes ☐ No

Gynecological: □ PCOS □ Menstrual Abnormalities
Other: _____

Family History: (Please Select & Identify)
□ Diabetes, Who: _____
□ High Blood Pressure, Who: _____
□ Cancer- Type: _____, Who: _____
□ Heart Disease, Who: _____
□ High Cholesterol, Who: _____

Family History Cont.
Mother: ☐ alive ☐ deceased
Cause of Death_____
Father: ☐ alive ☐ deceased
Cause of Death_____

□ Last Colonoscopy _____
□ Last Mammogram _____
□ Last Blood Work _____
□ Females: LMP _____
□ Primary Language if other than English:
_____

PATIENT PROFILE

Allergies to Medicines:

_____
_____
_____
_____

Previous Medical/Surgical History & Dates

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____
4._____ Date:_____

QUALITY OF LIFE

Please describe below, how you feel your excess weight is affecting the following aspects of your life.

Daily activities you cannot perform_____

Ability to exercise_____

Ability to perform job duties_____

Social activities you cannot participate in_____

Your marriage/relationships_____

Relationship with your children_____

Self-esteem_____

Does your excess weight cause pain? _____

GASTROESOPHAGEAL REFLUX DISEASE

Do you frequently suffer from heartburn or indigestion?.....Yes____No____

Do you frequently use antacids?.....Yes____No____

Have you ever had an upper GI or endoscopy?.....Yes____No____

Do you wake up at night with indigestion?……..…….…..…Yes____No____

EXERCISE HISTORY

Do you exercise regularly? ☐ Yes ☐ No

If yes, describe the type and frequency_____

If no, why? _____

What factors interfere with exercise? ☐Time ☐ Convenience ☐ Medical ☐ Motivation

What type(s) of exercise do you enjoy? _____

What type(s) of exercise do you dislike? _____

At what time of day do you prefer to exercise? _____

Do you enjoy exercising alone or in a group? _____

Do you have any physical limitations or injuries that prevent certain types of exercise? ☐ Yes ☐ No

If yes, what are they and how do they affect you? _____

PATIENT PROFILE

URINARY STRESS INCONTIENENCE

Do you leak urine when you cough, sneeze, or laugh?.....Yes____No____

Do you wear a pad to prevent urine from wetting your clothes?.....Yes____No____

STOP BANG ASSESSMENT

Have you been tested for sleep apnea?.....Yes____No____

If yes, when?_____

Do you snore?.....Yes____No____

Do you wake up in the middle of the night gasping for air?.....Yes____No____

Has anyone ever told you that you stop breathing while asleep?.....Yes____No____

Do you have restless sleep?.....Yes____No____

Do you have daytime sleepiness or doze off at inappropriate times?.....Yes____No____

Do you find yourself driving on "auto-pilot" without recall of the trip?.....Yes____No____

Do you have a dry throat upon awakening?.....Yes____No____

Do you dream during brief naps or before fully asleep?.....Yes____No____

Do you have headaches or muscle aches upon awakening?.....Yes____No____

Do you wake up frequently throughout the night?.....Yes____No____

PSYCHOLOGICAL/SUPPORT

Have you ever been diagnosed with a psychiatric condition?.....Yes___No___

If yes, what is the diagnosis? _____ Current treatment:_____

Have you ever been hospitalized for a psychiatric condition?.....Yes___No___

Do you or have you ever had a history of (Check all that applies):

☐ Binge Eating ☐Laxative use to control weight ☐ Compulsive eating ☐ Anorexia

☐ Bulimia (Binge eating followed by self-induced vomiting) ☐ Self-Induced vomiting

Why do you eat? (Check all that apply)

☐Hunger ☐ Boredom ☐Stress ☐Guilt ☐ Anger ☐ Control ☐Depression ☐Enjoy Taste

Which of the following are major stresses in your left? (Check all that apply)

☐Job ☐Children☐ Spouse☐Lack of available time ☐Running a household ☐Medical problems

Have you ever had psychological counseling for weight management? ☐ Yes ☐No

How do you rate your self-esteem? ☐High ☐ Fair ☐Low

PATIENT PROFILE

Please list all forms of previous attempts at weight loss. THIS MUST BE FILLED OUT.

Name of the diet/weight loss program	Length of time on the Program	Pounds Lost
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Binge Eating (Check all that apply)

☐ I have episodes of eating amounts of food definitely larger than most people would eat in a two-hour period

☐ I have a sense of lack of control over eating during the episode

During a binge eating episode, I: (Check all that apply)

☐ Eat much more rapidly than normal ☐ I eat alone because of embarrassment ☐ I eat until I feel uncomfortably full

☐ I feel disgusted with myself, depressed, or very guilty afterwards

☐ I eat large amounts of food when not feeling hungry

How many days per week do you binge eat? _____

How do you feel that losing excess weight will affect your life in the following areas?

Medical changes_____

Physical changes_____

Self-esteem_____

Occupational changes _____

Relationship changes_____

GOALS

What are your weight loss & health goals?

	Amount of weight loss	Fitness/Health Goals
In 1 Year	_____	_____
Target Weight	_____	_____

Do you feel you will be able to perform the work and have the dedication to achieve these goals? ☐ Yes ☐ No

Having weight loss surgery is not considered a "magic bullet" to losing weight rapidly, it takes commitment and it takes realistic goals. You will be asked to follow specific instructions in order to make your surgery a success. If you feel that you do not have to be compliant with these instructions and follow the diet, vitamin regime, and an exercise program, than please discuss these concerns with us before you decide to go ahead with having surgery. It is your responsibility to follow this plan as given and attend at least 2 support groups and classes offered by our program. The patient profile is correct to the best of my knowledge.

Patient Signature_____**Date**_____