





# Weight and Diet History:

Many insurance companies require physician documentation of weight for 5 years and supervised weight loss attempts. In an effort to expedite the approval process, you may want to contact your primary care physician for that documentation to be sent to us.

LIFESTYLE			
How many years have you been more than 75 pounds over weight?			Do you eat sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your lowest weight since you were 18 years old			If yes, how often?
What is your tallest height since you were 18 years old?			Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you been actively attempting to lose weight?			If yes, how many drinks per day?
What is the maximum amount of weight you have lost?			If yes, what beverages?
How did you accomplish that weight loss?			Do you use caffeine? (coffee, colas, chocolate <input type="checkbox"/> Yes <input type="checkbox"/> No
How long were you able to maintain that weight loss?			Energy drinks, pills such as No Doz or Jet alert)
How many times per day do you eat?			Are you a snacker? <input type="checkbox"/> Yes <input type="checkbox"/> No
What are your favorite foods?		If yes, what are your favorite snacks?	
Why do you think you failed with diet programs?			

OTHER				
Do you have any hearing impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what type?	
If yes, how many packs per day and for how long?			If yes, how many times per week?	
If No, did you ever smoke and when did you quit?			If no, what prevents you from exercising?	
Do you require any aides for mobility? Circle one: <input type="checkbox"/> Yes <input type="checkbox"/> No			Are there any religious or ethnic customs which may affect your healthcare? If so, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cane Walker Wheelchair				
<b>PLEASE NOTE: YOU WILL BE ASKED TO QUIT SMOKING PRIOR TO SURGERY TO DECREASE YOUR SURGICAL RISKS</b>				

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RESPIRATORY SYSTEM**

Shortness of breath with activity	<input type="checkbox"/> Yes <input type="checkbox"/> No		Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Frequent awakening to catch breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of last attack			Sleep apnea (stop breathing while asleep)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you use a C-PAP or BI-PAP machine (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, number of occurrences in last 2 years			Blood clots in lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, do you have a vena cave filter	
Are you on blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No		Emphysema or COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please list:				

## Sleep Apnea Self Test

For above respiratory section

Do you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been told that you hold your breath or stop breathing during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake up gasping for breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you awaken with headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you fall asleep frequently while reading?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you fallen asleep while driving or stopped at a light?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have jerking movements while sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you still feel exhausted after 8 hours of sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number of YES answers \_\_\_\_\_

If you answered YES to more than four of the above questions, you may have sleep apnea and either you should talk to your doctor about a sleep study, or we will make arrangements for one to be done. This study is painless and can significantly help improve the safety of the operation. If you have had a sleep study performed in the past 6 months, please fax or mail a copy of the results to our office.

**GENITOURINARY SYSTEM - FEMALES ONLY**

Urinary stress incontinence (loss of urine with coughing, sneezing, and/or laughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Polycystic ovarian syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular menstrual cycle	<input type="checkbox"/> Yes <input type="checkbox"/> No		Menopause	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heavy menstrual flow	<input type="checkbox"/> Yes <input type="checkbox"/> No		Have you had a hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you use birth control	<input type="checkbox"/> Yes <input type="checkbox"/> No

It is strongly recommended that female patients begin using birth control prior to surgery. Weight loss may improve fertility.

**NEUROPSYCHOLOGICAL SYSTEM**

Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, any paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No		History of drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where			If yes, how long have you been drug free	
Seizures requiring medication	<input type="checkbox"/> Yes <input type="checkbox"/> No		History of alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe Headaches requiring medication	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how long have you been alcohol free	
Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		Eating disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please circle: Bulimia, Anorexia, Compulsive Overeating	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, were you treated	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when and where?	
Do you see a psychiatrist or psychologist	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Please provide name and address below:	

Please answer all of the following questions related to your current or past medical history

### CARDIOVASCULAR SYSTEM

Hypertension (high blood pressure) requiring meds	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Shortness of Breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chest pain, angina or tightness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Fatigue	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Irregular or rapid heart rate	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Leg Ulcers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Congestive Heart Failure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Blood Clots in legs	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Murmur	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Varicose Veins	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mitral Valve Prolapse	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Ankle Edema (swelling of legs and feet)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High Cholesterol or triglycerides requiring meds	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
Do you see a cardiologist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Name:					
					Phone: ( )					
Have you had: stress test, cardiac catheterization, angioplasty or heart surgery?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, please circle all procedures that apply and indicate dates below:					

### ENDOCRINE SYSTEM

Diabetes requiring meds	<input type="checkbox"/>	Type 1	<input type="checkbox"/>	Type 2	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Hypoglycemia (low blood sugars)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Gestational Diabetes (with pregnancy)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				Hypothyroidism or thyroid problems		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Insulin resistance (elevated blood sugars)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Please send TSH level (thyroid test) drawn within last 6 months									

### MUSCULOSKELETAL SYSTEM

Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Have you had treatment by a chiropractor	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Degenerative disc disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Lupus	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Degenerative joint disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Do you take anti-inflammatory medications?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Joint pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, please list:					
If yes, circle sites affected: Neck Hands Back Hips Knees Ankles Feet						Have you had physical therapy treatment	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had a joint replacement or back surgery?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, when					
If yes, When						Fibromyalgia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

### GASTROINTESTINAL SYSTEM

Stomach ulcer requiring medication	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Gallbladder problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>If yes</b> , when and type of treatment						<b>If yes</b> , has your gallbladder been removed? Please also list date: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
GERD or heartburn	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Have you had x-rays that document gallstones	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, daily _____ At night _____					<b>If yes</b> , please send a copy of x-ray report					
Inflammatory bowel disease (chrones or ulcerative colitis)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Diarrhea	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Irritable bowel Syndrome	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		Constipation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No