Office use only:

MRN ____________

BMI _______

Please complete and return this form to be considered for evaluation

Name____________________________________ **Date** ______________

Age ________ **Date of Birth**_____/_____/_____ **Sex** M ☐ F ☐

Address__________________________**City**________________**State**____**Zip code** _________

Preferred Daytime Phone: (_____)______-________

Do you have email that is checked regularly? Can we use it as a way to contact you with appointment information? ☐ No ☐ Yes – **If Yes, please provide it** ________________________________

Type of weight loss services interested in:

☐ Medically Supervised Weight Loss ☐ Surgical Weight Loss ☐ Undecided ☐ Both

Preferred surgeon:

☐ Dr. Wheeler ☐ Dr. Ganga ☐ Dr. Pitt ☐ Dr. Spencer ☐ No Preference

Have you previously had bariatric surgery? ☐ NO ☐ YES*

When:____________ Where:______________________Type:___________________________

Reason(s) for seeking a revision: ____

*please provide original bariatric surgery op report and recent testing with this questionnaire

Primary Insurance:______________________**ID#**____________________Group#_______________

Policy holder________________Relationship_______**Customer Service Phone#** ____________________

Secondary Insurance:____________________**ID#**____________________Group#_______________

Policy holder________________Relationship_______**Customer Service Phone#** ____________________

☐ **Self-Referred**

☐ **Physician Referred - Name** ______________________________ **Phone (_____)______-________**

Current Height:_____feet_____inches

Current Weight ________

NOTE: Education regarding bariatric surgery is done in a group setting format due to the number of people requesting bariatric surgery. Please know that all personal information is kept private during these classes. It will be your decision to share personal information or ask individual questions during the group sessions.

OBESITY RELATED COMPLAINTS: (please X all that apply)
Have you EVER had any of the following:

Past / Now	Condition	Medication/Treatment needed (name and dosage)
☐ ☐	High blood pressure	
☐ ☐	Diabetes	
☐ ☐ ☐ ☐ ☐ ☐	Sleep Apnea w/ sleep study Daytime Sleepiness Snoring	
☐ ☐	Reflux (heartburn)	
☐ ☐	Heart disease	
☐ ☐ ☐ ☐	High Cholesterol High Triglycerides	
☐ ☐	Joint pain	
☐ ☐	Back pain	
☐ ☐	Hip pain	
☐ ☐	Knee pain	
☐ ☐	Ankle & foot pain	
☐ ☐	Swelling of feet	
☐ ☐	Urinary stress incontinence	
☐ ☐ ☐ ☐ ☐ ☐	Blood clots Deep vein thrombosis DVT Pulmonary embolism PE	
☐ ☐	Stroke	
☐ ☐	Shortness of breath	
☐ ☐	Asthma	
☐ ☐	Emphysema	
☐ ☐	Headaches	
☐ ☐	Migraines	
☐ ☐	Kidney disease	
☐ ☐	Seizures	
☐ ☐	Rashes	
☐ ☐	Arthritis / Osteoarthritis	
☐ ☐	Cancer	
☐ ☐	Irregular periods	
☐ ☐	Eating disorder	
☐ ☐	Non Alcoholic Fatty Liver or Non Alcoholic Steatohepatitis	
☐ ☐	Other (please specify) Additional space - next page	

Past / Now	Psychiatric History	Medications	Hospitalized for mental health	Dates hospitalized for mental health
☐ ☐	Depression		☐Yes	
☐ ☐	Severe depression		☐Yes	
☐ ☐ ☐ ☐	Schizophrenia Bipolar		☐Yes ☐Yes	
☐ ☐ ☐ ☐	Anorexia Bulimia		☐Yes ☐Yes	
☐ ☐	Treated by a mental health provider		☐Yes	
☐ ☐	History of suicide attempt?	When?	☐Yes	
☐ ☐	History of drug abuse treatment?	When?	☐Yes	

Mental Health History – explanations:

____

____

____

Family History (Check all those that apply)

Mother / Father	Condition
☐ ☐	Heart Disease
☐ ☐	Diabetes
☐ ☐	Hypertension
☐ ☐	Cancer – Type(s) ____
☐ ☐	Stroke
☐ ☐	Obesity
☐ ☐	Deep Vein Thrombosis (blood clot in legs)
☐ ☐	Pulmonary Emboli (blood clot in lungs)

Please list any health conditions in your immediate family:

____

____

____

Medication History: (Current)

Medication (s)	Dosage and Reason for Taking

MEDICAL HISTORY: (list any other conditions not addressed on previous page)

Condition:__________________________Medication:____________________Dosage:_______________

Condition:__________________________Medication:____________________Dosage:_______________

Condition:__________________________Medication:____________________Dosage: _______________

SURGICAL HISTORY:

Type:______________________________(Lap or open) Reason_______________________Date_________

Type:______________________________(Lap or open) Reason_______________________Date_________

Type:______________________________(Lap or open) Reason_______________________Date_________

Type:______________________________(Lap or open) Reason_______________________Date_________

Type:______________________________(Lap or open) Reason_______________________Date _________

SOCIAL AND PERSONAL HISTORY:
Highest level of education: ____
Occupation:____
Employer name: (for our records only) ____

Do you use tobacco/nicotine products? (chew, cigarettes, cigars, e-cig, pipes, etc)?

☐ Never
☐ Past - When quit? ____________
☐ Currently - How Much? ________________________

Do you have a <u>history</u> of either alcohol, drug/substance abuse? ☐ No ☐ Yes*

*If Yes do you <u>currently</u> use?
☐ No. What type did you use?__________________________When did you quit? ___________
☐ Yes. What type do you use?__________________________How often? __________________

EXERCISE PROGRAM (What is your exercise program**):**

☐ I am <u>unable</u> to exercise due to - ☐ severe joint pain ☐ shortness of breath ☐ wheelchair/bed
☐ I am <u>able</u> to exercise but I do not have a regular routine
☐ I currently exercise by doing: ____
☐ Other – (please explain) ____

DIETARY HISTORY:

Do you follow a special diet: **Currently?** ☐ no ☐ yes

Name/type of diet attempt____

Date started (**month/year**) _____/______

Beginning weight___________pounds lost____________pounds gained____________

Diet Programs/Prescription Drugs/Over the Counter Medications attempted: (mark all that apply)

Nutri-System	Medifast	ABS Diet	Blood Type Diet	Perricone Diet	Over Eaters Anonymous	Mediterranean Diet	Liquid Protein	Atkins Diet	Fit For Life
Diet Center	Gluten Free Diet	Zone Diet	Low Calorie Diet	Low Sugar Diet	Subway Diet	Vegan/Vegetarian Diet	Low Fat Diet	Exercise Videos	Herbal
High Protein	Cabbage Soup Diet	Grapefruit Diet	Jenny Craig	Fitness Centers	Magazine Diet	Self-Imposed Fasting	Hypnosis	Body for Life	Belly Off Diet
South Beach Diet	TOPS	Weight Watchers	Eat This, Not That Diet	Flat Belly Diet	Detox Diet	Diabetic Diet	Juice Diet	DASH Diet	Spark People Diet
Raw Food Diet	Ornish Diet	Paleolithic Diet	HCG Diet	Sugar Busters	The Cookie Diet	Phentermine	Tenuate	Amphetamine	Qsymia
Phen- Fen (Adipex)	Wellbutrin	Bontil	Belviq	Xenical	Ritalin	Didrex	Orlistat	Topomax	Meridia
Dexatrim	Hoodie	Metabolife	Zovetal	Sensa	Cortislin	Hydroxycut	Nanoslim	MuHaung	Relecore
Leptopril	Trim Spa	Alli	Lipozene	Stacker	Actislim	Green Tea Extract			

Which meals do you eat each day? ☐ Breakfast ☐ Lunch ☐ Supper

Do you snack? ☐ no ☐ yes How often? ☐ mid-morning ☐ afternoon ☐ evening ☐ just before bed

What do you typically eat for snacks?____

Do you drink milk? ☐ no ☐ yes What kind?____

Do you drink plain water? ☐ no ☐ yes How much? ____

Do you drink soda? ☐ no ☐ yes How often? ____

Do you drink juice? ☐ no ☐ yes How often? ____

Do you consume alcoholic beverages? ☐ No ☐ Yes - If yes, how many drinks per week? ___________

What other beverages do you drink? (tea sweet-unsweet, carbonated/sparkling water, energy, etc)

____

Do you have food allergies? ☐ no ☐ yes What? ______________________________________

Allergies:

Allergic to Latex? ☐ No ☐ Yes

Any known drug allergies? ☐ No ☐ Yes

If yes, list of drugs:

____

____

____