

PERSONAL DETAILS

Last Name: _____ First Name: _____

Address: _____

_____ Zip Code: _____

Telephone No: (Home) _____ (Office): _____

Mobile No: _____ Soc. Sec. # _____

Date of Birth: _____ Age: _____

Occupation: _____

Primary Insurance Company: _____ Policy No: _____

Secondary Insurance Company: _____ Policy No: _____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

1. NEXT OF KIN

Name: _____ Relationship: _____

Address: _____

Telephone No: (Home) _____ (Office): _____

2. ADDITIONAL CONTACT

Name: _____ Relationship: _____

Address: _____

Telephone No: (Home) _____ (Office): _____

REFERRAL INFORMATION

Referring Doctor: _____ Date of Referral: _____

Address: _____

Telephone Contact: _____ Fax No: _____

Specialist Physician: _____ Type of Specialist: _____

Address: _____

Telephone No: _____ Fax No: _____

Primary Care Physician: _____ Type of Specialist: _____

Address: _____

Telephone No: _____ Fax No: _____

EMPLOYMENT

Current Employment:

Are you currently employed? _____

Are you full-time or part-time? _____

If you are unemployed, what is the reason? _____

Are you actively looking for work? _____

Has your weight made it difficult to find employment? _____

If employed, please state what level of activity your job involves:

Little (sedentary job)

Moderately active

Very active (Labouring, etc.)

ALCOHOL CONSUMPTION

Do you drink any alcohol? Yes No

How often do you have a drink containing alcohol?

Every Day Most days Most weeks Most months Rarely (once or twice a year)

What is the main type of beverage you drink? Please circle one only.

Beer Wine Liquor

From the list below please **circle** the **main** alcoholic beverage you drink and check any other you would drink at times.

Beer Light Beer Red Wine White Wine

Liquor (specify) _____

When do you usually drink? Please circle the main one. Check any others that are relevant.

Social occasions Parties With meals Before / after meals Weekend session/s

If you indicated above that you drank everyday, most days or most weeks, please circle how many standard drinks you would have in a typical week. (1 standard drink = 1 small glass of wine, 1 glass of full strength beer or a 1 oz of liquor).

1-2 3-10 11-20 21-40 40+

ACTIVITY LEVEL

Do you exercise on a regular basis? Yes No

How many times per week: 0-2 3-5 5 or more

How many minutes each session _____

What type of exercise? _____

WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

	Weight	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight					
Weight at starting school (5-6 yrs)					
Weight at beginning of high school (10-12 yrs)					
Weight at end of high school (15-18 yrs)					
Weight at time of commencing work (21 yrs)					
Weight at time of marriage (if applicable)					

List any particular events that led to significant weight gain (e.g. pregnancy, quit smoking):

DIETARY HABITS

Please check the appropriate boxes below:

	Always	Sometimes	Never
Do you skip meals?			
Do you have sweet cravings?			
Do you eat large portion sizes?			
Do you eat out at restaurants or get take out?			
Do you snack?			
Do you eat foods too high in fat?			
Do you tend to eat more when you are stressed, angry, depressed, bored, etc.?			
Do you eat large amounts of food until you are uncomfortably full?			
Do you ever vomit after eating too much?			
Do you eat alone out of embarrassment?			
Do you have feelings of disgust, depression or guilt after over eating?			

How many meals do you generally eat each day? _____

How many times per day do you generally eat sweets? _____

How many caffeinated beverages do you drink per day? _____

How many sweetened beverages do you drink per day? _____

WEIGHT LOSS HISTORY

	Program	Date Started	Weight At Start	Months On Diet	Weight at End	Lbs. Lost	Time Until Regained
e.g.	Weight Watchers	1/99	210	6	190	20	6 mos
	Weight Watcher						
	Jenny Craig						
	Nutri-System						
	Atkins Diet						
	Very Low Calorie Diet						
	Liquid Diet Optifast Medifast Slimfast						
	Other Diet _____ _____ _____						
	Hypnosis						
	MD Supervised Program						
	Overeaters Anon						
	Weight Loss Clinic						
	Structured Exercise Program						
	Nutritional Counseling						
	Appetite Suppressants Phen/fen Redux Meridia Xenical Phentermine Amphetamines Fastin Attenuate Over-the-counter pills Herbal supplements						
	Surgery Liposuction Breast reduction Tummy tuck Lipectomy						

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/ CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / Sleep Apnea					
Asthma					
Allergies					
Hayfever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

ALLERGIES (including foods, medications): Yes No

If yes, please give details: _____

SURGICAL HISTORY

Please give details of any past operations:

Surgery	Date	Reason

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Hypoglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Congestive heart failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
High cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Thyroid disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Polycystic ovarian syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Infertility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Sleep apnea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Ulcer disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Reflux disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Hiatal hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Gallbladder disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
HIV	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Rheumatoid Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Osteoarthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Degenerative Disc Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Lupus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Anxiety disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Bipolar disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Schizophrenia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Alcoholism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Venous insufficiency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Blood clot in leg or lungs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____

REVIEW OF SYSTEMS

Are you having any of the following symptoms?

Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Shortness of breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Chest pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Joint pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Muscle pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Panic attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Difficulty sleeping	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Constipation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Leakage of urine with cough/sneeze	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Indigestion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Heartburn	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Abdominal pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Blood in urine/stool	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Difficulty urinating	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Impotence	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Pain in legs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Swelling in legs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Varicose veins	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Snoring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Excessive daytime sleepiness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Falling asleep inappropriately	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____
Waking up at night because you cannot breathe	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details: _____

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications. If yes, please state the name of the medication and how long you have been or were taking it.

- Medication for psychiatric disorder Yes No Details: _____
- Migraine medication Yes No Details: _____
- Medications for asthma or breathing Yes No Details: _____
- Hormones Yes No Details: _____
- “The Pill” Yes No Details: _____
- Cortisone Yes No Details: _____
- Estrogen Replacement Yes No Details: _____

Please list all other medications that you have used in the last 12 months.

<i>MEDICATION</i>	<i>DOSAGE</i>	<i>FREQUENCY</i>

VITAMINS / SUPPLEMENTS

Do you take multivitamin tablets / or other herbal remedies dietary supplements?

Yes No

If yes, how often do you take them?

Rarely Monthly Weekly Most days Every day

Please name the multivitamin or other dietary supplements you usually take.

FOR WOMEN ONLY

Do you have regular periods (26-33 days) Yes No
If not, please describe: _____

Do you have problems with excessively heavy periods Yes No
If Yes, please described _____

Have you had difficulty in conceiving in the past? Yes No

Do you currently have problems with infertility? Yes No

Have you suffered from excess body hair or acne? Yes No

Have you ever been told by a doctor that you have polycystic ovaries? Yes No

Have you had problems with pregnancy and/or childbirth? Yes No
If so, in what way _____

Have you had a caesarean section? Yes No
If so, why? _____

When was your last PAP test? _____

Was it normal Yes No

Are you sexually active Yes No

Do you use an form of birth control? Yes No

If yes, which one(s) _____

When was your last mammography _____

Was it normal Yes No

SLEEP HISTORY

Please place an **X** in the appropriate box.

	NEVER	SOMETIMES	ALWAYS
Do you snore?			
Do you wake during the night with a choking feeling?			
How often do you wake up more than once during the night?			
Do you have a headache when you wake up in the morning?			
Have you noticed a reduction in your sex drive?			
Do you feel sleepy during the day?			
Has anyone noticed that you momentarily stop breathing during the night?			
Do you wake up in the morning feeling confused?			
How often do you have a nap during the day?			
Do you feel sleepy in the evenings?			
Have you or anyone else noticed a change in your personality recently?			
How often do you doze off or fall asleep while driving?			

How likely are you to **doze off or fall asleep** in the following situation, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing an **X** the boxes below:

	(0) Never Doze	(1) Slight chance of dozing	(2) Moderate chance of dozing	(3) High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion:

Yes No Details: _____

If yes, how often do you have reflux during the day?

Many times a day everyday most days most weeks occasionally

Do you suffer from heartburn / indigestion during the night? If so how often?

Many times a day everyday most days most weeks occasionally

What aggravates or causes your reflux? _____

Details: _____

Do you have difficulty swallowing?

Yes No Details: _____

Does food ever get stuck?

Yes No Details: _____

Does food or fluid reflux into the mouth?

Yes No Details: _____

Do you vomit with reflux?

Yes No Details: _____

Do you suffer from recurrent sore throats?

Yes No Details: _____

Do you suffer from a hoarse voice?

Yes No Details: _____

Do you suffer from a regular cough at night?

Yes No Details: _____

Please list any treatments you may use for reflux / heartburn or indigestion:

How did you learn about our program? (Check all that apply)

- Talked with someone who had surgery. Who? _____
- Researched it through the internet.
- Read books or articles about it.
- Discussed it with a health provider
- Other _____

Why do you want weight loss surgery?

Is your spouse / significant other supportive of your decision to have weight loss surgery? Yes No

Explain: _____
