



Medical History



Date _____
 Name _____ Social Security Number ____-____-____
 DOB _____ Age _____ Height _____ Weight _____ BMI _____
 Primary care doctor _____

For office use only

Height ____ Weight ____ BMI ____ Neck ____ Goal ____ Ideal ____
 BMI>45 ____ Age>38 ____ Apnea ____ HbA1c ____ Insulin ____ Male ____

Past Medical History

Please circle the appropriate response

Abnormal Bleeding	yes	no	Blood clots in the legs	yes	no
Rheumatic fever	yes	no	Blood clots to the lungs	yes	no
Thyroid problems	yes	no	Diabetes currently	yes	no
Tuberculosis	yes	no	Diabetes while pregnant	yes	no
Urinary tract infections	yes	no	Age at onset of diabetes	_____	_____
Kidney disease	yes	no	Diabetes control	good	poor
Hepatitis	yes	no	Polycystic ovarian syndrome (PCOS)	yes	no
Do you have to take antibiotics before dental work	yes	no	Problems with anesthesia	yes	no
AIDS/HIV	yes	no	Hypertension (high blood pressure)	yes	no
			High cholesterol or triglycerides	yes	no

Past Surgical History Please list all surgeries and approximate dates (year)	Past Hospitalizations Please list all hospitalizations and approximate dates (year)	Comorbidities <i>office use only</i>

Review of Symptoms

<p>General</p> <p>Fevers yes no</p> <p>Sweats yes no</p> <p>Fatigue yes no</p> <p>Loss of appetite yes no</p> <p>Bloody sputum yes no</p> <p>Persistent cough yes no</p> <p>Skin</p> <p>Rash yes no</p> <p>Acne yes no</p> <p>Skin cancer yes no</p> <p>Senses yes no</p> <p>Visual problems yes no</p> <p>Hearing problems yes no</p> <p>Ear ringing yes no</p> <p>Neurological</p> <p>Dizziness yes no</p> <p>Migraines yes no</p> <p>Frequent headaches yes no</p> <p>Seizures yes no</p> <p>Strokes yes no</p> <p>Memory loss yes no</p> <p>Shaking yes no</p> <p>Numbness yes no</p> <p>Uncoordination yes no</p> <p>Genito-urinary</p> <p>Blood in urine yes no</p> <p>Vaginal infections yes no</p> <p>Stress urinary incontinence yes no</p> <p>Bladder/kidney infections yes no</p> <p>Prostate infections yes no</p> <p>Sleep apnea</p> <p>Snoring yes no</p> <p>Require C-pap yes no</p> <p>Daytime drowsiness yes no</p> <p>Frequent waking at night yes no</p> <p>Choking at night yes no</p> <p># of pillows used _____</p> <p>Pulmonary disease</p> <p>Short of breath on exertion yes no</p> <p>Hay fever yes no</p> <p>Emphysema/COPD yes no</p> <p>Pneumonia yes no</p> <p>Asthma yes no</p> <p>Aspiration/choking yes no</p>	<p>Infection</p> <p>HIV yes no</p> <p>AIDS contact yes no</p> <p>TB exposure yes no</p> <p>Swollen glands yes no</p> <p>Recurring infections yes no</p> <p>Skin infections yes no</p> <p>Exercise Limitations</p> <p>Mild yes no</p> <p>Moderate yes no</p> <p>Severe yes no</p> <p>Pain in joints</p> <p>Back yes no</p> <p>Hips yes no</p> <p>Knees yes no</p> <p>Feet yes no</p> <p>Arthritis</p> <p>Where? _____</p> <p>Gastrointestinal</p> <p>Heartburn/acid reflux yes no</p> <p>Stomach pains yes no</p> <p>Stomach ulcers yes no</p> <p>Gastritis yes no</p> <p>H. pylori infection yes no</p> <p>Rectal bleeding yes no</p> <p>Liver disease yes no</p> <p>Hepatitis or cirrhosis yes no</p> <p>Colitis or enteritis yes no</p> <p>Frequent diarrhea yes no</p> <p>Frequent constipation yes no</p> <p>Crohn's disease yes no</p> <p>Stomach surgery yes no</p> <p>Physical limitations</p> <p>Climbing stairs yes no</p> <p>Unusual fatigue yes no</p> <p>Airline travel yes no</p> <p>Lifting from floor yes no</p> <p>Use of public seating yes no</p> <p>Personal care yes no</p> <p>Tying shoelaces yes no</p> <p>Playing with children yes no</p> <p>Gynecological (females only)</p> <p>Last menstrual period _____</p> <p>Pregnancies _____</p> <p>Current contraception _____</p> <p>Any chance you are currently pregnant yes no</p> <p>Intending pregnancy in the next 2 years yes no</p>
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Review of Symptoms *(continued)*

Cardiovascular			Psychological		
Heart attack	yes	no	Depression	yes	no
Congestive heart failure	yes	no	Feeling down	yes	no
Thrombophlebitis	yes	no	Suicidal episodes	yes	no
Swelling of ankles	yes	no	Mood swings for days at a time	yes	no
Chest pain	yes	no	Hospitalized for psychiatric reasons	yes	no
Coronary heart disease	yes	no	Use alcohol or drugs to cope	yes	no
Varicose veins	yes	no	Hospitalized for substance abuse	yes	no
Heart murmur	yes	no	Eating disorder	yes	no
Pulmonary embolism	yes	no	Vomiting to lose weight	yes	no
Stroke	yes	no	Fasting to lose weight	yes	no
Ever taken Fen-Phen	yes	no	Laxatives to lose weight	yes	no
Have you had an echocardiogram?	yes	no	Life more stable than a year ago	yes	no
			History of sexual abuse	yes	no
			Psychiatric medications in past or present	yes	no
			Overeat in reaction to feelings	yes	no

Medications

List all daily medications including over-the-counter medications and vitamins, herbs or supplements, and contraceptives

Name	Dosage	Frequency	Reason

Do you take any of the following over-the-counter medications regularly?

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	No

Allergies

List any known allergies or sensitivities

Medication Allergy	Reaction

List any allergies and sensitive to the following:

				Reaction
Latex	yes	no	_____	_____
Dye	yes	no	_____	_____
Iodine	yes	no	_____	_____
Tape	yes	no	_____	_____

Other allergies: _____

Social History

Marital status Single Married/Partnered Divorced/Separated Widowed

Religious preference _____

Ethnic background _____

Education _____

Number of people living in your home _____ Who? _____

What type of work do you do? _____

What type of hobbies or activities do you do? _____

Do you currently smoke? yes no Do you drink alcohol? yes no

Have you ever smoked more than 100 yes no Drinks per day _____

cigarettes? yes no How often _____

Age started _____ Do you use controlled yes no

Age last smoked _____ substances? _____

Average cigarettes per day _____ How often _____

Total years smoking _____

How does your spouse, partner, family, friends, and significant others feel about your weight loss surgery?

For adolescents only

Highest grade in school _____		GPA _____	
School performance	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very good	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
School name: _____			
History of frequent school absence	yes	no	_____
Are you sexually active? _____			
Do you smoke marijuana	yes	no	_____
Do you take street drugs	yes	no	_____



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Family Medical History

Please indicate if you have a family history of the following:

	Parent	Sibling or Child	Other Relatives <i>cousins, aunts, grandparents, etc</i>	No Family History	Don't Know
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Cancer <i>(specify type)</i>					
Depression					
High Cholesterol					
Osteoporosis					

Weight Loss History

Age you first became overweight _____ Weight comfortably maintained _____

Highest adult weight _____ Lowest adult weight _____

Please circle all that apply

Grew up: overweight normal weight active in sports under wt. average wt.

Weight gain after: pregnancy marriage divorce separation quit smoking
 moved desk job injury gradual

Please check all that apply.

Non-Supervised Attempts

Body For Life/Bill Phillips	
Gloria Marshall	
Health spa	
High protein	
Hypnosis	
Low carbohydrate	
Low fat	
Calorie counting on my own	
Gym membership	
Home gym equipment	

Atkins Diet	
AYDS	
Mayo Clinic Diet	
Pritikin	
Richard Simmons	
Scarsdale Diet	
Stillman Diet	
Sugar Busters	
Slim Fast	
South Beach Diet	
Other	



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Supervised Weight Loss Attempts

Diet Pills From MD		Supervised Calorie Counting	
Diet Shots From MD		Acupuncture	
Diet Center		Psychological Counseling	
Overeaters Anonymous		Weigh Of Life	
Optifast		Weight Loss Center	
Weight Watchers		Exercise Counseling	
Health Management Resources (HMR)		Medifast	
Nutri-System		Metrical	
T.O.P.S.		Nutritional counseling	
Jenny Craig		Personal Trainer	
New Direction		Other	
National Weight Loss			

Weight Loss Medications

Acutrim		Obalan	
Adipex-P		Orlistat	
Amphetamines		Phendiet	
Anorex		Phentermine	
Benzphetamine		Phentrol	
Dexatrim		Plegine	
Didrex		Pondimin	
Fastin		Redux	
Fenfluramine		Sanorex	
Herbal Remedies		Tepanol	
Ionamin		Tenuate	
Mazanor		Wehless	
Meridia		Xenical	
Metabolife		Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)		Gastric band	
Stomach stapling		Other	
Vertical banded gastroplasty			

Nutrition History

How many meals do you eat daily			
Do you snack between meals	yes	no	
Do you drink soda	yes	no	
Diet	yes	no	
Regular	yes	no	
How many sodas do you drink daily			

Food Preferences

Candy	yes	no	Fast food	yes	no
Cookies	yes	no	Seafood	yes	no
Fried food	yes	no	Cakes or pies	yes	no
Pizza	yes	no	Vegetables	yes	no
Chocolate	yes	no	Steak or red meat	yes	no
Chips and snacks	yes	no	Dairy products	yes	No

Food allergies _____

TYPICAL DAILY INTAKE

PLEASE RECORD THE TYPICAL TYPES OF FOODS AND THE AMOUNTS YOU EAT ON A REGULAR BASIS.

- Before breakfast
- Breakfast
- Morning break
- Lunch
- Afternoon snack
- Dinner
- After dinner
- Before bed
- Other