PLEASE COMPLETE FORM PRIOR TO INITIAL OFFICE VISIT

WEIGHT MANAGEMENT PATIENT HEALTH HISTORY FORM

DEMOGRAPHIC INFORMATION

Today's Date: _____

Last Name: _____First Name: _____MI:____

Date of Birth: _____Age:_____ SS#:_____

Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Widowed □ Divorced

Address:_____

City: _____State:_____ Zip code:_____

Phone*: Home_____ Cell_____ Work_____ Fax_____

*Which number should we contact you at first? □ Home □ Cell □ Work

*May we contact you at your work number? □ Yes □ No

E-mail Address:_____

May we contact you via e-mail? □ Yes □ No

EMPLOYMENT INFORMATION

Employment Status: □ Full Time □ Part Time □ Self Employed □ Homemaker □ Student

□ Retired□ Unemployed □ Disabled – if yes, provide reason_____

Employer: _____Occupation:_____

Address:_____

City: _____State:_____ Zip code:_____

SPOUSE INFORMATION

Name: _____DOB:_____

Employer:_____ Occupation:_____

Address:_____

City: _____State:_____ Zip code:_____

EMERGENCY CONTACTS

Name: _____Relationship to patient:_____

Phone: Home:_____ Cell:_____

Address:_____

City: _____State:_____ Zip code:_____

Name: _____Relationship to patient:_____

Phone: Home:_____ Cell:_____

Address:_____

City: _____State:_____ Zip code:_____

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Insurance Information

Have you contacted your insurance carrier regarding coverage for the program? yes no
Will your insurance plan provide coverage for Obesity Treament Services? yes no
Has your insurance coverage been verified by our department?* yes no

If yes, please provide your insurance carrier information:

Primary Insurance_____ Subscriber name_____
DOB:_____ Relationship_____ Insured employer_____

ID#/ Contract#_____ Group#_____ Phone _____

Seconary Insurance_____ Subscriber name_____
DOB:_____ Relationship_____ Insured employer_____

ID#/ Contract#_____ Group#_____ Phone _____

I authorize the release of any medical information necessary to process this claim:

_____ Date_____
signature of patient/ responsible party

Physician Information

Physician	Name:	Address:	Phone
Primary care:			
Cardiologist:			
Pulmonologist			
Gynecologist			
Orthopedic surgeon			
Endocrinologist			
Psychologist/ psychiatrist			
Other:			

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Patient history **Please circle medical problems you have or have had in the past:**

Heart			**Lung**			**Liver**		
Angina	MI	CHF	asthma	COPD	emphysema	fatty liver	cirrhosis	mono
HTN	arrythmia/ IRR HR		shortness of breath			Hepatitis		
high cholesterol		WPW	sleep apnea/OSA			other:		
Renal/ Kidney			**Cancer:**			**Musculoskeletal:**		
Kidney stones		insufficiency	type:_____			arthritis	neck pain	back pain
renal failure		proteinuria	treatment: chemo radiation			fibromyalgia		
other:			Year treated:_____			other:		
Urologic:			**Endocrine**			**Neurological**		
impotence	sexual dysfuntion		diabetes: type 1 type 2			seizure	syncope	stroke
UTI	incontinence		Years: _____ Average glucose:_____			headaches	head injury	
other:			Thyroid	other:		other:		
GI:			**Mental:**			**Hematology**		
hiatal hernia	GERD	Gastroparesis	depression	anxiety	dementia	bleeding disorder		
constipation	diarrhea	dysphagia	Alzheimer's	Eating disorder		clotting disorder		
nausea/ vomitting		ulcer	Other:			Factor V Leiden		
pancreatitis	gallstones					transfusion reaction		
Infectious disease			**Reproductive:**					
HIV	TB	MRSA	Polycystic ovaries			Please use a separate sheet as needed		
C. Diff	hepatitis	STD	Infertility					
other:			Current pregnancy					

Previous hospitalizations:_____

_____

Previous Surgery: _____

_____

Family History

check box	father	mother	brothers	sisters	Father's father	Father's mother	Mother's father	Mother's mother
asthma								
heart attacks								
cancer								
diabetes								
gallbladder disease								
HTN								
strokes								
weight problems								
arthritis								
seizures								
anesthetic problems								

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Medications:

name	dose	freqency	purpose

Allergies:	reaction:	**Allergies:**	reaction:

Immunizations:

(record the date/ year given if known)

Tetanus:_____ Flu:_____ Varicella/ Shingles:_____

Pneumonia:_____ Hepatitis:_____ other:_____

****

I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important that the physician have complete and accurate information in order to provide safe medical evaluation, recommendations, and care. I understand that this medical history is used in providing care through the weight management center and that some information may need to be shared with other providers or counselors.

_____ _____/_____/_____

signature date

Furthermore, I agree to allow my photgraphs to be used for statistical/ education purposes.

_____ _____/_____/_____

signature date

I agree to allow my family member/ friend listed below to have access to my medical information:

Names:_____

_____ _____/_____/_____

signature date

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Name_____

DOB_____

Social History. Do you currently vape? Yes No

1. Do you currently smoke or use tobacco? YES NO If yes, how much?_____
   If past, when did you quit?_____ Number of years:_____
2. Do you eat sweets frequently? YES NO If yes, how much?_____
3. Do you drink alcohol? YES NO If yes, how much?_____
4. Do you/ have you ever used illegal drugs? YES NO Explain_____
   _____
5. Do you drink caffeinated beverages? YES NO If yes, how much?_____
6. Marital status:_____
7. Do you have children? YES NO If yes, list ages: _____
8. Do you wear any of the following? Dentures Hearing aid Glasses CPAP/BIPAP
9. Do you exercise? YES NO If yes, how much?_____
10. Are there barriers that prevent you from exercising?_____
11. What is your occupation?_____
    Do you do heavy lifting? Explain:_____
12. Please list your hobbies and recreational activities:_____
    _____
13. Educational level:_____

Personal Weight History

current weight_____ height_____ BMI_____

highest weight_____ lowest adult weight_____ Ideal weight_____

Excess weight began: Childhood Puberty After pregnancy As an adult

other:_____

Years overweight_____

Where is most of your weight located: waistline hips arms/ legs face all

What has been your greatest single weightloss in the past? # pounds:_____

How?:_____

How long did you sustain the weight loss?_____

Have you had previous weight loss surgery? YES NO Explain:_____

_____

Sleep Apnea Assessment

Sleep apnea is often associated with excess weight. Your physician will use this assessment as one of the tools to determine if a referral is necessary to St. Rita's Sleep Disorders Center.

STOP BANG Questionnaire

☐ **I am treated for sleep apnea. If not, circle approapriate answer:**

1	**Snoring.**	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES NO
2	**Tired**	Do you often feel tired, fatigued, or sleepy during daytime?	YES NO
3	**Observed**	Has anyone observed you stop breathing during your sleep?	YES NO
4	**Blood Pressure**	Do you have or are you being treated for Hypertension?	YES NO
5	**BMI**	Is your BMI more than 35?	YES NO
6	**Age**	Age over 50 yr old?	YES NO
7	**Neck circumference**	Is your neck circumference greater than 40 cm?	YES NO
8	**Gender**	Are you male?	YES NO

*High risk of OSA: answering yes to three or more items **total YES *: _____**

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Weight Loss History

Please provide detailed history on your previous attempts at weight loss.

This information may be used to meet insurance requirements, if applicable

circle programs used:	# of attempts	dates	time	weight lost	weight regained
Medically supervised programs:					
Meal replacement programs: Medifast Ideal Protein HMR Optifast other:					
Medications: Fen-Phen Alli Redux Dexedrine Meridia Qsymia Adipex Xenical Belviq Diurex Topamax Metformin					
Behavior Modification: Natually slim counseling Where:_____					
Alternative health: Accupuncture hypnosis					
Dietitian prescribed Where:_____					
Personal trainer Where:_____					
Commercial programs:					
Weight watchers					
Jenny Craig					
Tops					
Nutrisystem					
Specific diet types					
Low calorie diets: Slimfast SouthBeach Grapefruit diet Cambridge diet other:					
Low fat diets: Dean Ornish AHA diet					
High Protein/ Low Carb diets: Atkin's Mediterranean Diabetic diet Other:					
Other:					
Richard Simmons Susan Powter Beverly Hills Stillman The Zone Pritkin LA Weight loss					
Supplements: Metabollife Dexatrim Herbalife fill bars Fat burners Dieter's tea other:					
Other: Weight loss surgery Gastric balloon Jaw wiring liposuction					

Name_____

DOB_____

24 hour diet recall

Please list all foods and quantities consumed in the las 24 hour period. Include everything taken in and be as precise as possible listing portion size and provide time of day to the best of your recollection.

Breakfast

snack

lunch

snack

dinner

snack

Physical activity in the past 24 hours:

Physical activity weekly regimen:

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DOB_____

Please rate your readiness to change: 1 2 3 4 5 6 7 8 9 10

not sure thinking about it need more information Let's go!

Note any barriers to change: _____

_____

_____

Personal Statement Please describe in your own words why you are asking to have medically supervised weight management or weight loss surgery. Include how your weight has affected your health, your employment, your relationships, or your social life. Please use additional paper if needed.