PATIENT INFORMATION

Please fill in all the information on the following pages using a pen, not a pencil.

You must fill this form out in its entirety; if a question does not pertain to you, please mark that question N/A. If form completely filled out we will not be able to schedule a consultation appointment for you. Thank you!

Name: _____ _____ _____
First Middle Last

Date of Birth: _____

Race: African American American Indian Asian Caucasian Hispanic Other

1. Primary Care Physician: _____

2. Weight History:

How long have you been obese (Lifelong or from what age)? _____

Within a 20-pound weight gain or loss, how many years have you been at your current weight? _____

3. Medical Problems: Please read carefully and make sure you write an "X" on each line for any of the following **medical problems for which you are being treated by a physician**.

Arthritis _____	Back Pain _____	COPD _____
Cushing's Disease _____	Diabetes _____	Difficulty Walking _____
Heart Problems _____	Hepatitis _____	High Blood Pressure _____
High Cholesterol _____	High Triglycerides _____	Insomnia _____
Osteoarthritis _____	Shortness of Breath _____	Sleep Apnea _____

4. Please write an "X" on each line for any of the following other medical conditions that you may have**:**

Asthma _____	Coronary Artery Disease _____	Deep Vein Thrombosis (DVT) _____
Depression _____	Dysmetabolic Syndrome _____	Lower Extremity Edema _____
GERD _____	Headaches _____	Hiatal Hernia _____
Infertility _____	Dermatitis _____	Irregular Periods _____
Joint Pain _____	Liver Disease _____	Malaise/Fatigue _____
Pancreas Disease _____	Peptic Ulcer _____	Pickwickian Syndrome _____
Snoring _____	Stroke _____	Polycystic Ovary Disease _____
Thyroid Problems _____	Urinary Incontinence _____	Varicose Veins _____

5. Surgical History: Please list all of your operations. Attach additional form if needed.

	TYPE OF SURGERY	Month/Year
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

6. Medications that you take on a regular basis:

Include both prescription and non-prescription drugs and vitamins/supplements. If you need more room please attach and staple to this packet. You must include name, strength, dose and reason for taking.

	Name of Medication	Strength	Dose (Daily, occasionally, as needed)	Reason for taking
Ex:	**Atenolol**	**100 mg**	**1 daily**	**High Blood Pressure**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

7. Allergies to medications: (circle answer)

N/A **YES** (If yes, please fill out medication name and reaction)

Name of Medications	Reaction it causes (Example: rash, difficulty breathing, etc.)
_____	_____
_____	_____

8. Family History: Please check all that apply, list all relatives and label each with M or P: **(Maternal (M) =Mother's side or Paternal (P) =Father's side)**

Example: __X__ Arthritis Which Relatives (M or P): ____Grandmother (M) _____

_____ Anesthesia Problem Which Relatives (M or P): _____

_____ Arthritis Which Relatives (M or P): _____

_____ Bleeding Disorder Which Relatives (M or P): _____

_____ Diabetes Which Relatives (M or P): _____

_____ Heart Disease Which Relatives (M or P): _____

_____ Hypertension Which Relatives (M or P): _____

_____ Seizures Which Relatives (M or P): _____

_____ Stroke Which Relatives (M or P):_____

_____ Obesity Which Relatives (M or P): _____

_____ Cancer: (Please list type of Cancer and which relative)

Type _____ Which Relatives (M or P): _____

Type _____ Which Relatives (M or P): _____

9. Social History:

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Employment: Full-time: _____ Part-time: _____Occupation: _____

Are you on disability? Yes _____ No _____ Reason for disability: _____

Use of alcohol: Yes _____ No _____ if yes, how many drinks per day: _____

Use of tobacco: Yes _____ No _____ if yes, how much per day: _____

Former Smoker: Yes _____ No _____ How much _____ Year started _____ Year Quit _____

Use of recreational drugs: Yes _____ No _____ if yes, how much per day**:** _____

Type/frequency: _____

Used in the past: YES _____ NO _____ If YES, how long ago? _____

Type/frequency: _____

10. Problems in daily living because of obesity:

List problems you have **at your job** due to your size, weight or weight-related physical problems, such as shortness of breath. (Example: Don't fit in regular office chairs, can't easily reach computer keyboard, sitting for long periods causes back pain or feet swelling). List problems you have in your **personal/ family** life due to obesity and related problems. (Examples: Personal hygiene is hard because I cannot reach where I need to. I don't fit into public restrooms. Other examples of difficulties could be: Playing or caring for children, getting out of the bathtub, can't bike ride with family, avoid social activities because of embarrassment about your size, doing yard work, housework, bathing, dressing, sex, taking walks, bending).

_____
_____
_____
_____
_____
_____
_____

11. The following lines are for you to tell us anything we might have missed that you think we should know.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

YOUR NAME (Please print): _____

YOUR SIGNATURE: _____DATE_____

****

(Office Use Only)

Triage Nurse Signature: _____ Date: _____