

Name: _____ DOB: _____ Date: _____



COMPREHENSIVE OBESITY MANAGEMENT PROGRAM

PATIENT HISTORY FORM

Patient Name: _____ Male Female
DOB: _____ Age: _____ Marital Status: S M W D SEP
Occupation: _____
Spouse/Significant Other's Name _____ Phone # _____
Emergency Contact Name _____ Phone # _____

Height	Weight

Goal Weight: _____ Age when you were last at goal weight: _____

Do you have any spiritual practices, of which you would like to make us aware, that would impact the medical care plan we would provide for you? Yes No

Your Family History: Please check which of the following conditions that your blood-related family members have experienced. Please indicate by circling which family member was affected.

Diabetes	Mother	Father	Other _____
Hypertension	Mother	Father	Other _____
Heart Disease	Mother	Father	Other _____
Obesity	Mother	Father	Other _____
Osteoporosis	Mother	Father	Other _____
Seizure	Mother	Father	Other _____
Anemia	Mother	Father	Other _____
Asthma	Mother	Father	Other _____
Arthritis	Mother	Father	Other _____
Thyroid Disease	Mother	Father	Other _____
Kidney problems	Mother	Father	Other _____
Early Death	Mother	Father	Other _____
Lipid/Cholesterol Problems	Mother	Father	Other _____
Cancer (type) _____	Mother	Father	Other _____
Neurological Disorder (Parkinson's)	Mother	Father	Other _____
Alzheimer's Disease	Mother	Father	Other _____
Other _____	Mother	Father	Other _____

Your Medical History:

When was your last physical exam with your primary care physician? _____

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Sleep History:

Briefly describe your sleep pattern _____

Have you had a sleep study? Yes No If yes, please provide date _____

Epworth Sleepiness Scale: Use the following scale to choose the most appropriate number for each situation.

- 0 = would *never* doze or sleep
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping (0, 1, 2, 3)
Sitting and Reading	
Watching TV	
Sitting inactive in public place	
Being a passenger in a moter vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
TOTAL Score (add up the scores)	

Please mark all that apply:

Respiratory:

- Sleep Apnea COPD
- Snore Asthma
- Headaches Emphysema
- Feel exhausted after 8 hours of sleep TB
- Hold breath or stop breathing when sleeping Blood clot in lungs
- Environmental/Seasonal Allergies Bronchitis
- Shortness of Breath: On stairs/ hills
- At Rest, Walking

Do you use a BIPAP or CPAP? yes, no

Wake up gasping for breath Fall asleep while reading or driving

Musculoskeletal:

- Arthritis Back Pain Spinal Disc problems
- Knee Pain Gout Fibromylagia
- Chronic Fatigue Fractured hip, wrist or spine (circle)
- Other _____

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Nervous System:

____ Neuropathy ____ Parkinson's disease ____ Epilepsy/seizures
____ Dizziness ____ Headache/Migranes ____ Stroke (CVA)
____ Other Neurological Disorders _____
____ Serous Problems with memory or difficulty thinking _____

Gastrointestinal:

____ Ulcers ____ Reflux/GERD ____ Hernia
____ Crohn's Disease ____ Ulcerative Colitis ____ Hemorrhoids
____ Colon Polyps ____ Diverticulosis ____ Hepatitis
____ Liver Disease ____ Gallbladder Disease ____ Dental Problems
____ Change in Bowels ____ Other _____

Cardiac:

____ Angina/Chest Pain ____ Congestive Heart Failure ____ Heart Attack
____ Coronary Artery Disease (____ year)
____ Heart Murmur ____ Irregular or Rapid Heart Beat
____ High Cholesterol ____ High Blood Pressure

Endocrine:

____ Diabetes ____ Infertility ____ Irregular periods
____ Hypothyroidism ____ Hyperthyroidism ____ Excessive hot/cold
____ Visual Changes ____ Voice Changes
____ Abnormal hair growth ____ Increase in thirst or urination
____ Other _____

Ear and Nose:

____ Cataracts ____ Macular degeneration ____ Glaucoma
____ Sinus Infections ____ Hearing loss/hearing aid ____ Wear glasses
____ Wear contacts ____ Hay Fever

Blood Disorders:

____ Anemia ____ Bleeding or clotting problems
____ Iron Deficiency ____ Other _____

Vascular:

____ Leg Ulcers ____ Edema (Swelling of Legs)
____ Peripheral Vascular Disease

Genitourinary:

____ Kidney disease ____ Prostate disease ____ Difficulty urinating
____ Kidney Transplant ____ year
____ Frequent bladder or kidney infections
____ Other _____

OB / GYN:

____ Number of pregnancies ____ Number of Children
Date of onset of menses _____
Date of onset of menopause (if applicable) _____

Name: _____ DOB: _____ Date: _____

Cancer:

Cancer Type: _____ Year: _____

Treatment: _____

Social History:

Current Smoker: _____ Yes _____ No Date Quit: _____
_____ Cigarettes, _____ pipe, _____ cigar, _____ packs per day x _____ years

Alcohol: Never Rare (Holidays) Occassionally (weekends) Frequently
_____ # of drinks per day _____ # times per week.

Other substance:

Type & Use _____

Surgical History: Please list any illnesses or operations that required hospitalization:

Year	Illness/Operation	Year	Illness/Operation

Have you undergone any previous gastric surgery, stomach stapling? _____ Yes, _____ No

Do you have any other health concerns? _____

Weight History:

How would you classify your mother's weight?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your father's weight?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your weight at age 5?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your weight at age 15?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your weight at age 25?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your weight at age 35?

Obese _____ Overweight _____ Average _____ Below Average _____

How would you classify your weight at age 45-50?

Obese _____ Overweight _____ Average _____ Below Average _____

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Are you currently at your highest weight? ___Yes ___No
If no, what was your highest weight & when? _____

What is your expected weight loss after treatment?: _____

Diet History:

Please list all diet attempts that you can remember starting with the most recent. It may be difficult to remember this information, but try to estimate the date (month, year) from start to finish and how many pounds were lost. For programs more than 5 years ago, just indicate the year.

Diet Programs: (Some examples are: Atkins, South Beach, Weight Watchers, Jenny Craig, Slimfast, Over the counter diet aids, Ephedra)

Diet	Starting Date: (Month/Year)	Ending Date: (Month/Year)	Pounds Lost

Prescription Diet Medications: (Please check the medications you have taken)

Medication	Starting Date: (Month/Year)	Ending Date: (Month/Year)	Pounds Lost
<input type="checkbox"/> Fen-Phen			
<input type="checkbox"/> Phenteramine (Fastin, Adipex)			
<input type="checkbox"/> Meridia (sibutramine)			
<input type="checkbox"/> Xenical (orlistat)			
<input type="checkbox"/> Other:			

Eating Behaviors:

Are you currently following a diet? Yes No If yes, which diet: _____
Are you currently taking vitamins? Yes No If yes, please list them: _____
Do you have any food allergies/intolerances? Yes No
If yes, please list them: _____

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Please check the following behaviors that contribute to your weight problems:

- Skip meals/Inconsistent meal pattern Specify: _____
- Frequent Snacking-day, night or both Specify: _____
- Portion Control Specify: _____
- Eating too fast Specify: _____
- Sweets (sugar, candy, cookies, ice cream) Specify: _____
- Starches (breads, pastas, potatoes) Specify: _____
- Fats (fried foods, butter, margarine) Specify: _____
- Fast Food Specify: _____
- Emotional Eating- stress, boredom, depression, anger (**circle one**)
- Binge eating (eating unusually large amounts of food with lack of self control)
If checked off, when was your last binge and what food did you binge on?

- Purging/Vomiting/Laxatives to lose weight
If checked off, please describe when, how long, and were you professionally treated?

Please answer the following:

How many meals per day do you eat? ___ How many snacks do you eat per day? ___

Who cooks your meals? _____

Do you eat breakfast regularly? Yes No

List the beverages you drink mostly? _____

Do you drink water? Yes No If yes, how much per day? _____

What are your worst food habits? _____

Which food do you crave the most? _____

How often do you eat at fast food restaurants? _____

If you eat fast food, which restaurants do you frequent? _____

Typical Eating Pattern:

Breakfast	
Lunch	
Dinner	
Snacks	

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Physical Activity Assessment:

How did you get here today? Drove myself family member drove me
 Public transportation Other _____

Are you currently exercising? Yes, No If yes, what type and how often?

Have you used an exercise program or physical activity in the past as part of a weight loss program? Yes No

If yes, what type of activity did you perform & how often? _____

Type of Activity	Frequency (how long & how often? Example: 20 mins., once per week, 1 hr. per month, 5 minutes daily, etc.)
<input type="checkbox"/> Swimming	_____
<input type="checkbox"/> Walking	_____
<input type="checkbox"/> Gardening	_____
<input type="checkbox"/> Exercise class (kind of class)	_____
<input type="checkbox"/> Yoga	_____
<input type="checkbox"/> Tai Chi	_____
<input type="checkbox"/> Bicycle	_____
<input type="checkbox"/> Weight Lifting	_____
<input type="checkbox"/> Other _____	_____

Please list any activities you enjoyed as a child. _____

Please check the box that best describes the role you believe physical activity will have as a realistic part of your weight loss program?

Extremely important Somewhat important Not important

Please describe your current living situation; do you live: in the city
 outside the city.

Do you have someone who will exercise with you? Yes No

Please rate these daily activities as follows: 1= Challenging 2= Somewhat challenging
3=Not challenging/Easy

Getting out of bed in the morning	_____
Brushing your teeth	_____
Getting dressed	_____
Going up/down stairs	_____
Performing household chores	_____
Driving	_____
Performing errands/shopping	_____
Walking short distance	_____
Walking to the bathroom	_____

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If you have ever received any kind of Physical or Occupational therapy please list the condition and date of treatment below:

Condition _____ Dates _____

Condition _____ Dates _____

Psychosocial History:

Have you ever participated in counseling or psychotherapy? Yes No

Have you ever been treated for depression/anxiety disorder? Yes No

If yes, where, when and duration of treatment: _____

Do you have a family history of mental illness or addiction (for example, alcohol or drug?) Yes No If yes, please list the relation to you & the addiction.

Have you ever attempted suicide? Yes No
If yes please describe when & the circumstances. _____

Have you ever been a victim of abuse (physical, emotional, or sexual) Yes, No

Are you planning any major life changes in the next year? Yes, No
If so, what? _____

What is the most significant source of stress at this time? _____

What is your method of coping with stress? _____

Who will make up your support system? What is their relationship to you? _____

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Weight Loss Readiness:

Choose the reason(s) which best describe why you are pursuing weight loss at this time?

- _____ To avoid medical disability in the future
- _____ To better manage current medical problems
- _____ To avoid or reduce social criticism from others
- _____ To feel better about myself
- _____ Other (specify) _____

Compared to previous attempts, how motivated are you to lose weight at this time?

- _____ Not motivated _____ Slightly motivated _____ Somewhat motivated
- _____ Quite motivated _____ Extremely motivated

How certain are you that you will stay committed to a weight reduction program for the time it will take to reach your goal weight?

- _____ Not certain _____ Slightly certain _____ Somewhat certain
- _____ Quite certain _____ Extremely certain

To what extent will you be committed to this program considering all outside factors at this time in your life (work, family, obligations, etc.)?

- _____ Not committed _____ Slightly committed _____ Uncertain
- _____ Somewhat committed _____ Very committed

I am interested in: _____ Gastric Bypass _____ Lap-Band

_____ Undecided

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Provider List:

It is important that we keep your health care providers informed of your health status. Please complete the following. This is required information!

Telephone and Fax Numbers

Primary Care Physician

_____ Phone _____ Fax _____

Address: _____

Pulmonologist

_____ Phone _____ Fax _____

Gastroenterologist

_____ Phone _____ Fax _____

Orthopedist

_____ Phone _____ Fax _____

Neurologist

_____ Phone _____ Fax _____

Cardiologist

_____ Phone _____ Fax _____

Psychiatrist

_____ Phone _____ Fax _____

Endocrinologist

_____ Phone _____ Fax _____

Gynecologist

_____ Phone _____ Fax _____

Patient

Signature _____ **Date** _____

_____ **Date**

**Reviewed with patient by Babak Moeinolmolki, M.D./ Peter Liao, M.D. /
Kate Reinhardt, CRNP**