



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 _____
_____	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? _____

Sleep History:

Briefly describe your sleep pattern _____

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

Please mark all that apply:

Respiratory:

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

Do you use a BIPAP or CPAP? yes, no

Wake up gasping for breath Fall asleep while reading or driving

Musculoskeletal:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Spinal Disc problems
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Gout	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Fractured hip, wrist or spine (circle)	
<input type="checkbox"/> Other _____		

Nervous System:

<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headache/Migranes	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Other Neurological Disorders _____		
<input type="checkbox"/> Serous Problems with memory or difficulty thinking		

Gastrointestinal:

<input type="checkbox"/> Ulcers	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Hernia
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Change in Bowels	<input type="checkbox"/> Other _____	

Cardiac:

<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Coronary Artery Disease		(<input type="checkbox"/> year)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Irregular or Rapid Heart Beat	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure	

Endocrine:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infertility	<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Excessive hot/cold
<input type="checkbox"/> Visual Changes	<input type="checkbox"/> Voice Changes	
<input type="checkbox"/> Abnormal hair growth	<input type="checkbox"/> Increase in thirst or urination	
<input type="checkbox"/> 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) _____

Cancer:

Cancer Type: _____ Year: _____
Treatment: _____

Social History:

Smoker: ____ Yes, ____ No
____ Cigarettes, ____ pipe, ____ cigar, ____ packs per day x ____ years

Alcohol:

Social drinker, habitual drinker ____ # of drinks per day/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? _____

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: _____

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	

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.)

- Swimming _____
- Walking _____
- Gardening _____
- Exercise class (kind of class) _____
- Yoga _____
- Tai Chi _____
- Bicycle _____
- Weight Lifting _____
- 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 _____

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? _____

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

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 David G. von Rueden, M.D./ Babak Moeinolmolki, M.D./ Kathi Storm, C.R.N.P.