

**ADVANCED MEDICAL WEIGHT LOSS**

**Bariatric Health History**

Name \_\_\_\_\_ Age \_\_\_\_ Date of birth \_\_\_\_\_ Today's date \_\_\_\_\_

Occupation \_\_\_\_\_ Retired? *Yes No*

Sex: *Male Female* Marital status: *Married Single Divorced Widowed*

Referred by \_\_\_\_\_ Primary care provider \_\_\_\_\_

Desired weight \_\_\_\_\_ Reason you want to lose weight \_\_\_\_\_

Weight at age 20 \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Were you overweight as a child? \_\_\_\_\_

Maximum non-pregnant weight and when \_\_\_\_\_ Age you started gaining weight? \_\_\_\_\_

<b><u>Previous Diets</u></b>	Dates	Weight lost	Dates	Weight lost
1. _____	_____	_____	4. _____	_____
2. _____	_____	_____	5. _____	_____
3. _____	_____	_____	6. _____	_____

<b><u>Medication and Strength</u></b>	How Often	How Often	How Often
1. _____	_____	4. _____	7. _____
2. _____	_____	5. _____	8. _____
3. _____	_____	6. _____	9. _____

**Medication allergies, sensitivities and intolerances:** \_\_\_\_\_

<b><u>Past Surgery</u></b>	Year	Year	Year
1. _____	_____	3. _____	5. _____
2. _____	_____	4. _____	6. _____

<b><u>Other Hospitalizations</u></b>	Year	Year	Year
1. _____	_____	2. _____	3. _____

Are you a smoker? *Yes No* Packs per day \_\_\_\_\_ How many years? \_\_\_\_\_  
 Are you a former smoker? *Yes No* Packs/day \_\_\_\_\_ Years smoked \_\_\_\_\_ Year quit \_\_\_\_\_  
 Do you drink alcohol? *Yes No* Drinks per day/week/month \_\_\_\_\_  
 Are you a recovering alcoholic? *Yes No* When did you quit? \_\_\_\_\_  
 Do you use marijuana or other drugs? *Yes No* \_\_\_\_\_  
 Do you drink caffeinated drinks? *Yes No* Ounces/glasses per day \_\_\_\_\_  
 Do you drink coffee? *Yes No* Ounces/glasses per day \_\_\_\_\_  
 Do you take herbal/natural medicines? *Yes No* List \_\_\_\_\_

**Diet History**  
 Is your significant other overweight? *Yes No NA* How much? \_\_\_\_\_  
 Do you plan and cook your meals? *Yes No* If not, who does? \_\_\_\_\_  
 Do you have food cravings? *Yes No* List those foods \_\_\_\_\_  
 Do you snack? *Yes No* List what and when \_\_\_\_\_  
 Typical breakfast \_\_\_\_\_  
 Typical lunch \_\_\_\_\_  
 Typical dinner \_\_\_\_\_  
 Do you eat when stressed? *Yes No* List major stressors \_\_\_\_\_  
 List any other eating triggers besides stress and hunger \_\_\_\_\_  
 How often do you eat out? \_\_\_\_\_ At which restaurants? \_\_\_\_\_  
 How often do you eat "fast food"? \_\_\_\_\_ At which restaurants? \_\_\_\_\_  
 How many days per week do you exercise? \_\_\_\_\_ Type and length \_\_\_\_\_  
 Do you compensate for overeating by fasting, vomiting, exercising or using laxatives? *Yes No*  
 Do you hide your eating from others? *Yes No*

**Please circle any of the following illnesses and/or medical problems you have or have had:**

Glaucoma	High cholesterol	Anemia	Depression
Lung disease	Gallbladder problems	Endometriosis	Anxiety
Thyroid problems	Stomach/duodenal ulcers	Tuberculosis	AIDS or HIV
Emphysema	Reflux/heartburn	Blood clots in arteries or veins	Bleeding problems
Pneumonia	Diverticulosis	Migraines	Convulsions/seizures
Hay fever	Colitis	Breast problems	Arthritis
Asthma	Hepatitis	Osteoporosis	Gout
High blood pressure	Liver trouble	Prostate problems	Cancer
Heart attack	Eating disorder	Kidney/bladder problems	Diabetes
Arteriosclerosis	Anorexia Nervosa	Kidney stones	Intravenous drug abuse
Stroke	Bulimia/binge eating	Other: _____	

**Your Biological Family History (list all members, even if healthy)**

<u>Relation</u>	<u>Sex</u>	<u>Age, if living</u>	<u>Age at death</u>	<u>Medical prob./cause of death: "Well" if healthy</u>	<u>Overweight?</u>	
Father		_____	_____	_____	Yes	No
Mother		_____	_____	_____	Yes	No
Brother/Sister	_____	_____	_____	_____	Yes	No
	_____	_____	_____	_____	Yes	No
	_____	_____	_____	_____	Yes	No
	_____	_____	_____	_____	Yes	No
	_____	_____	_____	_____	Yes	No

**If not listed above, please indicate if a brother, sister, mother or father have had any of the following:**

High blood pressure _____	Blood clots in arteries or veins _____	Glaucoma _____
Stroke _____	Heart disease _____	Depression _____
Diabetes _____	Cancer _____	Alcoholism _____
Tuberculosis _____	Asthma _____	Emphysema _____
Suicide _____	Other _____	

**Review of Body Systems**

	Never or not bothersome	Frequent or bothersome		Never or not bothersome	Frequent or bothersome
Severe headaches	_____	_____	Constipation	_____	_____
Nose or throat problems	_____	_____	Diarrhea	_____	_____
Shortness of breath	_____	_____	Bloody, black stools	_____	_____
Cough blood	_____	_____	Painful urination	_____	_____
Wheezing	_____	_____	Urgency with urination	_____	_____
Chest pain with exercise	_____	_____	Nighttime urination	_____	_____
Joint pains	_____	_____	Lose urine control	_____	_____
Rapid or irregular heart beat	_____	_____	Dark or bloody urine	_____	_____
Swollen ankles or feet	_____	_____	Weakness or paralysis	_____	_____
Fainting spells	_____	_____	Numbness	_____	_____
Nausea	_____	_____	Tremors	_____	_____
Trouble swallowing food	_____	_____	Lose balance	_____	_____
Vomiting blood	_____	_____	Coordination problems	_____	_____
Eye pain	_____	_____	Mood instability	_____	_____
Falling asleep at work or when driving	_____	_____	Stop breathing when asleep	_____	_____
Feeling down, depressed or hopeless	_____	_____	Loss of interest or pleasure	_____	_____

**Females only:**

Age menstruation started \_\_\_\_\_ How often do you have periods? \_\_\_\_\_ How long are your periods? \_\_\_\_\_  
 How many pregnancies have you had? \_\_\_\_\_ How many live children did you have? \_\_\_\_\_  
 Do you use birth control? Yes No Describe \_\_\_\_\_  
 Have you gone through menopause? Yes No Symptoms \_\_\_\_\_