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Last name, First, Middle	Date of Birth	Sex M F	Marital Status M D S W
Street Address	Ethnicity: Caucasian/African-American/Asian/Hispanic/ Native-American/East-Indian/Filipino/Other (**circle one**)		
City State Zip code	Home Phone	Cell Phone	
Employers Name	Work Phone	**E-mail Address**	
Employer's Street Address	Social Security Number	Driver's License# & State	
City State Zip code	Occupation		
Emergency Contact: Relationship	Work Phone		
Street Address, City, State, ZIP	Home Phone	Cell Phone	

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? ❑TV ❑Radio ❑Newspaper/Magazine ❑Seminar

❑**Doctor** (Name:_____) ❑ **Friend/Family** (Name: _____)

❑**Internet** (Website:_____) ❑ Other (Please Speicfy:_____)

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Patient Signature: _____Date: _____

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough. Blue or black ink only, please.

AGE_____ **DATE_____**

GENDER_____

PRESENT WEIGHT	HEIGHT	BMI	DESIRED WEIGHT

WEIGHT HISTORY/EVALUATION

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

Pregnancy related Weight History (female patients only):

Pregnancy #1 Year_____ Weight at start_____ at delivery_____

Pregnancy #2 Year_____ Weight at start_____ at delivery_____

Pregnancy #3 Year_____ Weight at start_____ at delivery_____

Pregnancy #4 Year_____ Weight at start_____ at delivery_____

DIETARY HISTORY/EVALUATION

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program			Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes❑	No ❑				
Nutri-Systems	Yes❑	No ❑				
Weight Watchers	Yes❑	No ❑				
OptiFast	Yes❑	No ❑				
Medi Fast	Yes❑	No ❑				
Fen/Phen/Redux	Yes❑	No ❑				
Meridia	Yes❑	No ❑				
Lindora	Yes❑	No ❑				
T.O.P.S.	Yes❑	No ❑				
O.A.	Yes❑	No ❑				
Acupuncture	Yes❑	No ❑				
Metabolife	Yes❑	No ❑				
Atkins Diet	Yes❑	No ❑				
Pritikin Diet	Yes❑	No ❑				

List any physician-supervised and documented weight loss attempt: _____

_____

List any other diets and/or weight loss methods you've tried: _____

_____

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from **1– like very much** to **4– don't care.**

_____Soda/Soft drinks	_____French fries	_____Chips/snacks
_____Steaks/chops	_____Candy	_____Potatoes
_____Chocolate	_____Pasta	_____Cookies
_____Pizza	_____Cakes/pies	_____Salad dressings
_____Fried foods		

CO-MORBIDITIES: *Have you had, or do you have, any of the following illnesses or symptoms?*

*(***Some of these questions may be redundant, however please complete to the best of your ability***)*

1. High Blood Pressure: Yes❑ No ❑

If Yes: ♦Year Diagnosed_____

♦List medications _____

__No history of HTN
__Borderline, No Meds
__Diagnosis of HTN, no Meds
__Treatment with single med
__Treatment with multiple meds
__Poorly controlled by meds, organ Damage

2. Congestive Heart Failure: Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

__ No Hx or s/s of CHF
__Class l: s/s with more than ordinary activity
__Class ll: s/s with ordinary activity
__Class lll: s/s with minimal activity
__Class lV: s/s @ rest

3. Ischemic Heart Disease : Yes❑ No ❑

Do you have, or have you had:

❑ Angina
❑ M.I. (myocardial infarction, "heart attack")
❑ CABG (coronary artery bypass graft)
❑ Abnormal EKG
❑ Stress test to rule out cardiac problems
❑ Palpitations
♦List medications _____

__ No Hx of ischemic heart disease
__ Abnormal ECG, no active Ischemia
__ History of MI or Anti-ischemic Meds
__ PCI, CABG
__ Active Ischemia

4. Angina Assessment ;

❑ Chest pain Yes❑ No ❑
❑ Chest pain with exercise Yes❑ No ❑
❑ Chest pain at rest Yes❑ No ❑
❑ M.I. (myocardial infarction, "heart attack")Yes❑ No ❑

__No chest pain s/s or Angina
__Anginal chest pain on with extreme exertion (running/swimming)
__Anginal chest pain with moderate activity/exertion
__Anginal chest pain with minimal exertion (walking across The room or "at rest"
__Unstable Angina
__Previoius MI by Hx or by current w/u (wall motion abnormality

5. Peripheral Vascular Disease : Yes❑ No ❑

Do you have, or have you had:

❑ Pain in your lower legs
❑ Pain in your lower legs with walking
❑ Pain in your lower legs while asleep

__No s/s of PVD
__Asymptomatic with Bruit
__Claudication, Anti-ischemic meds
__Transient ischemic attack, Rest Pain
__Procedure for PVD
__Stroke, loss of tissue secondary to Ischemia

6. Lower Extremity Edema (Swelling): Yes❑ No ❑

If Yes: ♦Do you have Edema (Swelling)? Yes❑ No ❑
♦Scaly & Thick Skin? Yes❑ No ❑
♦Leg Ulcers? Yes❑ No ❑
Medications/Treatment_____

__No s/s of lower extremity edema
__Intermittent LE edema, not requiring treatment
__S/S requiring treatment (diuretics, elevation, hose)
__stasis ulcers
__Disability, decreased function, hospitalization

7. Deep Venous Thrombosis / Pulmonary Embolism: Yes❑ No ❑

__No history of DVT/PE
__History of DVT resolved with anticoagulation
__Recurrent DVT with long term anticoagulation meds
__Previous PE
__Recurrent PE, decreased function, hospitalization
__Vena Caval filter

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8. Glucose Metabolism (Diabetes Type II): Yes❑ No ❑

__No s/s or evidence of Diabetes
__Elevated fasting glucose
__Diabetes, controlled with oral meds
__Diabetes, controlled with insulin
__Diabetes, controlled with Insulin and oral meds
__Diabetes, with severe complications
(Retinopathy, neuropathy, renal failure, blindness)

If Yes: ♦Year Diagnosed:_____

- Gestational: Yes❑ No ❑
- Neuropathy: Yes❑ No ❑
- Retinopathy Yes❑ No ❑
- Renal failure Yes❑ No ❑
- Blindness Yes❑ No ❑

♦Controlled with: ❑ Diet
❑ Oral Medication (list) _____

♦Last fasting blood sugar: _____

9. Lipids (Dyslipidemia/Hyperlipidemia): Yes❑ No ❑

__Not present
__Present, no treatment required
__Controled with lifestyle change, including step1/step2 diet
__Controlled with single medication
__Controlled with multiple medications
__Not controlled

High Cholesterol: Yes❑ No ❑
High Triglycerides: Yes❑ No ❑
If Yes: ♦Year Diagnosed _____

♦List medications: _____

10. Gout (Hyperuricemia) : Yes❑ No ❑

__No s/s of gout/hyperuricemia
__Hyperurecemia, no s/s
__Hyperuricemia, medications
__Arthropathy
__Destructive joints
__Disability, unable to walk

If Yes: ♦Gouty Arthritis? Yes❑ No ❑

Medications?_____

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11. Obstructive Sleep Apnea Syndrome: Yes❑ No ❑

__No s/s or evidence of OSA
__Sleep Apnea s/s (negative sleep study/not done)
__Sleep Apnea Diagnosis by sleep study (no oral appliance)
__Sleep Apnea requiring oral appliance (CPAP)
__Sleep Apnea with Significant Hypoxia/O2 dependant
__Sleep Apnea with complications (Pulm HTN)

If Yes: ♦Year Diagnosed:_____
♦Last sleep study:_____ month/year
♦**CPAP** used: Yes❑ No ❑

Trouble Sleeping? Yes❑ No ❑

- ♦Morning headaches Yes❑ No ❑
- ♦Daytime drowsiness Yes❑ No ❑
- ♦ Restless sleep Yes❑ No ❑
- ♦Snoring Yes❑ No ❑
- ♦Awakenings at night Yes❑ No ❑
- ♦Observed apneas Yes❑ No ❑

*****(PLEASE FILL OUT THE SLEEP EPWORTH SCALE FORM)*****

Epworth Sleepiness Scale	**Never** would doze off	**Slight Chance** of dozing	**Moderate Chance** of dozing	**High Chance** of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0❑	1❑	2❑	3❑
2. Do you get sleepy, or doze off, while watching TV?	0❑	1❑	2❑	3❑
3. While sitting or inactive in a public place (meeting, theater)?	0❑	1❑	2❑	3❑
4. As a passenger in a car for an hour without a break?	0❑	1❑	2❑	3❑
5. Lying down to rest in the afternoon	0❑	1❑	2❑	3❑
6. Sitting and talking to someone?	0❑	1❑	2❑	3❑
7. Sitting quietly after lunch without alcohol?	0❑	1❑	2❑	3❑
8. In a car, while stopped for a few minutes at a traffic light?	0❑	1❑	2❑	3❑
		Total Score (Sum of all numbers checked above)		

12. Obesity Hypoventilation Syndrome: Yes❑ No ❑

__No s/s of OHS
__Hypoxemia/hypercarbia on room air
__Severe hypoxemia or hypercarbia
__Pulmonary hypertension
__Right Heart Failure
__ Right Heart Failure – Left ventricular dysfunction

13. Pulmonary Hypertension: Yes❑ No ❑

__No s/s or indication of pulmonary htn
__s/s associated with PH(tiredness, SOB, dizziness, fainting)
__confirmed PH diagnosis
__well controlled on anticoagulants and/or calcium channel blockers
__Stronger meds and/or oxygen
__Patient needs or has lung transplant

14. Asthma: Yes❑ No ❑

If Yes: ♦Year Diagnosed:_____

♦ER visits/last 2 yrs: _____

♦Hospitalizations last 2 years:_____

♦Steroids last 2 years: Yes❑ No ❑

♦List medications_____

__No s/s of Asthma
__Intermittent mild s/s, no meds
__s/s controlled with oral inhaler (such as albuterol)
__well controlled with ongoing daily meds
__s/s not well controlled, steroids or anticholinergics
__hospitalized within the last 2 years, history of intubation

Shortness of breath (Dyspnea on Exertion) : Yes❑ No ❑

If Yes, : ♦Can walk _____blocks

♦Stairs: _____ flight

15. Gastro-Esophageal Reflux Disease: Yes❑ No ❑

(Heartburn/esophagitis/hiatus hernia)? Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____
♦Upper GI series? Yes❑ No ❑
♦Endoscopy? Yes❑ No ❑
♦Medications: _____
_____
♦Frequency of use: _____

Belching up acid or sour fluid. Yes❑ No ❑

Coughing or choking at night? Yes❑ No ❑

__No hx of GERD
__Intermittent/variable symptoms, no meds
__Intermettent medicaion
__H2 blockers/low dose PPI
__High dose PPI
__Meet criteria for Antireflux surgery/Prior surgery for GERD

16. Cholelithiasis: Yes❑ No ❑

If Yes: How was it Diagnosed?
❑ Ultrasound
❑ Physical Exam

Did you already have surgery? Yes❑ No ❑

Emergently or electively

Do you still have problems? Yes❑ No ❑

__No history of gallstones
__Gallstones with no s/s
__Gallstones with intermittent s/s
__Gallstones with severe s/s or h/o cholecystectomy
__Gallstones with complications requiring immediate surgery prior to Gastric Bypass
__h/o cholecystectomy with ongoing complications not resolved

17. Liver disease: Yes❑ No ❑

__No history of liver disease
__Hepatomegaly modest, normal LFT's, Fatty change Category 1
__Modest or greater hepatomegaly, LFT alteration, Category 2
__Moderate to marked hepatomegaly, Category 3, Mild inflammation/mild fibrosis
__Definite NASH, cirrhosis, Hepatic Dysfunction by LFT's
__Hepatic Failure, Transplant indicated or done

18. Back Pain: Yes❑ No ❑

If Yes: ♦Seen by Chiropractor? Yes❑ No ❑
♦Orthopedic Surgeon? Yes❑ No ❑
♦Seen by Family Doctor? Yes❑ No ❑

Medications taken: _____

_____

__No s/s of back pain
__S/S requiring non-narcotic treatment
__Degenerative changes/positive objective findings, s/s requiring narcotic treatment
__Surgical intervention done or recommended pending Weight loss
__Failed previous surgical intervention with existing s/s

19. Musculoskeletal Disease: Yes❑ No ❑

If Yes: ♦Seen by Chiropractor? Yes❑ No ❑
♦Orthopedic Surgeon? Yes❑ No ❑
♦Seen by Family Doctor? Yes❑ No ❑

Pain in: Back? Yes❑ No ❑
Hips? Yes❑ No ❑ (Right/Left/Both)
Knees? Yes❑ No ❑ (Right/Left/Both)
Ankles? Yes❑ No ❑ (Right/Left/Both)
Feet? Yes❑ No ❑ (Right/Left/Both)

__No s/s of musculoskeletal dz
__Pain with community ambulation
__Non-narcotic analgesia required
__Pain with household ambulation
__Surgical intervention required (Arthroscopy)
__Awaiting or past joint replacement or other disability

♦Medications taken: _____

20. Fibromyalgia : Yes❑ No ❑

If Yes, Specify Treatment:
_____
_____
_____

__No hx of Fibromyalgia
__Treatment with exercise
__Treatment with non-narcotic meds
__Treatment with narcotics
__Treatment with narcotics: Surgical intervention done or recommended
__Disabling, treatment not effective

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21. Polycystic Ovarian Syndrome : Yes❑ No ❑

Menstrual irregularities Yes❑ No ❑
Excess Body hair Yes❑ No ❑
Infertility Yes❑ No ❑

Medications:_____
_____

__No hx of PCOS
__s/s of PCOS, no treatment
__OCP's or Anti-androgen Rx
__Metformin or TZD
__combination therapy
__Infertility

22. Menstrual Irregularities: Yes❑ No ❑

Are your periods irregular? Yes❑ No ❑
Have you had a Hysterectomy? Yes❑ No ❑

__No hx of menstrual irregularities
__Irregular periods/oligomenorrhea
__Menorrhagia
__Amenorrhea
__Prior total abdominal hysterectomy

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23. Psychosocial Impairment : Yes❑ No ❑

__No impairment
__Mild impairment in psychosocial functioning but able to perform all primary tasks
__Moderate impairment in psychosocial functioning but able to perform most primary tasks
__Moderate impairment in psychosocial functioning and unable to perform primary tasks
__Severe impairment in psychosocial functioning and unable to perform most primary tasks
__Severe impairment in psychosocial and unable to function

24. Confirmed Mental Health Diagnosis: Yes❑ No ❑

__None
__Bipolar disorder
__Anxiety/panic disorder
__Personality disorder
__Psychosis

Anxiety disorder? Yes❑ No ❑
If Yes: ♦Year Diagnosed: _____
Have you been treated : Yes❑ No ❑
If Yes: type of treatment: ❑ Counseling
❑Hospitalization
♦Medications taken:_____

Panic disorder? Yes❑ No ❑
If Yes: ♦Year Diagnosed: _____
Have you been treated Yes❑ No ❑
If Yes: type of treatment: ❑Counseling
❑Hospitalization
♦Medications taken:_____

Bipolar disorder? Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

Have you been treated Yes❑ No ❑

If Yes: type of treatment: ❑Counseling

❑Hospitalization

♦Medications taken:_____

Personality disorder? Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

Have you been treated? Yes❑ No ❑

If Yes: type of treatment: ❑Counseling

❑Hospitalization

♦Medications taken:_____

Psychosis? Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

Have you been treated? Yes❑ No ❑

If Yes: type of treatment: ❑Counseling

❑Hospitalization

♦Medications taken: _____

25. Depression: Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

Have you been treated? Yes❑ No ❑

If Yes: type of treatment: ❑Counseling

❑Hospitalization

♦Medications taken:_____

_____

__No s/s of Depression
__mild and episodic, not requiring treatment
__Moderate, accompanied by some impairment, may require treatment
__Moderate with significant impairment, treatment indicated
__Severe, definitely requiring intensive treatment
__Severe requiring hospitalization

26. Alcohol Use: Yes❑ No ❑

If Yes, How frequent?_____

__None __Rare __Occasional __Frequent

27. Tobacco Use: Yes❑ No ❑

If Yes, How frequent?_____

__None __Rare __Occasional __Frequent

28. Substance Abuse (Illegal): Yes❑ No ❑

If Yes, How frequent?_____

__None __Rare __Occasional __Frequent

29. Stress Urinary Incontinence : Yes❑ No ❑

Leakage of urine with laughing/coughing/sneezing? Yes❑ No ❑

If Yes: ♦Wear pads frequently? Yes❑ No ❑

__No hx of SUI
__Minimal and intermittent
__Frequent but not severe
__Daily occurrence, requires sanitary pad
__Disabling
__Operation ineffective

30. Pseudotumor Cerebri (HEADACHES):Yes❑ No ❑

Do you experience Headaches? Yes❑ No ❑
Do youexperience any associated symptoms? Yes❑ No❑
If Yes, What are your symptoms?_____
_____
Were any studies done to evaluate? Yes❑ No❑
Was an MRI done? Yes❑ No ❑
Treatment/Medications?_____
_____

__No s/s
__Headaches with dizziness, nausea, and/or controlled with diuretics.
__Headaches with visual s/s and/or controlled with diuretics
__Patient has had MRI to confirm PTC, is well controlled oral diuretics.
__Patient is well controlled with stronger medications
__Patient requires narcotics or has had (or needs) surgical intervention.

31. Abdominal Hernia: Yes❑ No ❑

Date of diagnosis?_____
Have you had surgical repair? Yes❑ No ❑
Has your hernia come back? Yes❑ No ❑

__No hernia
__Asymptomatic hernia, no prior operation
__Symptomatic hernia with or without incarceration
__Successful repair
__Recurrent hernia or size > 15 cm
__ chronic evisceration through large hernia with associated complication or multiple failed hernia repairs.

32. Functional Status (AMBULATORY): Yes❑ No ❑

Do you have difficulty walking? Yes__No__
Do you require a cane to walk? Yes__No__
Can you walk more than 200 feet? Yes__No__
Do you require a wheel chair? Yes__ No__

__No impairment of functional status
__Able to walk 200 ft with assistance device (cane or Crutch)
__Cannot walk 200 ft with assistance device (cane or Crutch)
__Requires wheel chair
__Bedridden

33. Abdominal Skin/Pannus: Yes❑ No ❑

Do you have a large pannus? Yes❑ No ❑
Have you experienced:
skin irritation? Yes❑ No ❑
infections? Yes❑ No ❑
ulcerations? Yes❑ No ❑
interference with ambulation? Yes❑ No ❑
Have you required surgical treatment? Yes❑ No ❑

__No s/s
__Intertriginous irritation
__Pannus so large it interferes with ambulation
__Recurrent cellulitis, Ulceration
__Surgical treatment required

MEDICATIONS/Vitamins/Minerals:

Please list below all medications you currently use: ❑ ***See attached list***

Medication	Dose and Frequency	Purpose

❑Multi-Vitamins ❑Vitamin B12 ❑ Iron ❑ Calcium with Vitamin D

❑Vitamin D ❑ Calcium ❑Vitamin A, D, E Combo

PAST MEDICAL HISTORY

Allergies: Allergic to any medications?: Yes❑ No ❑ If Yes, please list medication and reaction:

_____

_____

_____

Allergic to:

Surgical tape: Yes❑ No ❑ Reaction: _____

Latex: Yes❑ No ❑ Reaction: _____

Iodine: Yes❑ No ❑ Reaction: _____

Other Allergies:

_____

_____

Serious Illnesses:

Have you had:

❑ Hepatitis ❑ Blood Transfusion ❑ AIDS/HIV Exposure

❑ Colitis ❑ Kidney Disease ❑ Bleeding Abnormality

❑ Heart Disease ❑ Pulmonary Disease ❑ Peptic Ulcer Disease

❑ Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced:

Major Illness Date Treatment

_____

_____

_____

_____

PAST SURGICAL HISTORY

Major Surgery Date

_____

_____

_____

_____

Have you had any problems with anesthesia? Y/N Have you had any problems with wound infections? Y/N

SOCIAL HISTORY

Occupation: _____since_____
Mo day year

Marital Status: ❑Single ❑Married ❑Divorced ❑Widow

Live at: ❑home ❑Apartment with ❑Spouse/Significant Other &/or ❑Children (how many?_____)

Do you use **tobacco**: Yes❑ No ❑ Frequency: _____
Are you willing to quit? Yes❑ No ❑ or When did you quit?_____
Mo day year

Do you use **alcohol**: Yes❑ No ❑ Frequency: _____

Do you use **drugs**: Yes❑ No ❑ Frequency: _____

FAMILY HISTORY

Family Member	Living?	Age	Overweight?	If Deceased, Age	Illness/Cause of death
Mother			Yes❑ No ❑		
Father			Yes❑ No ❑		
Maternal Grandmother			Yes❑ No ❑		
Maternal Grandfather			Yes❑ No ❑		
Fraternal Grandmother			Yes❑ No ❑		
Fraternal Grandfather			Yes❑ No ❑		
Sibling:			Yes❑ No ❑		
Sibling:			Yes❑ No ❑		
Sibling:			Yes❑ No ❑		
Sibling:			Yes❑ No ❑		

Please indicate if there is a family history of:

❑ Lung disease, Asthma or Emphysema
❑ Diabetes ❑Kidney Disease
❑ High Blood Pressure ❑ Bleeding tendency or Blood Disorder
❑ Heart Disease ❑ Breast Cancer
❑ High Blood Cholesterol ❑ Colon Cancer

CHILDHOOD & OTHER PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

❑ Measles ❑ Mumps ❑ Chickenpox ❑ Obesity
❑ Rheumatic fever ❑ Heart murmur ❑ Asthma ❑ Tonsillectomy

Female Patients:

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Number of miscarriages _____

Number of abortions: _____

Obstetric complications: _____

Do you presently use:

Birth control pills Yes❑ No ❑ List type: _____

Estrogens Yes❑ No ❑ List type: _____

Other Contraceptive method: _____

Tubal Ligation: Yes❑ No ❑ Laparoscopic or open

Hysterectomy : Yes❑ No ❑ Vaginal or Trans-abdominal (open)

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy Nose – runny Nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze

- Men: discharge from penis – loss of erection – painful erection
- Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – xray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

PERSONAL PHYSICIANS:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician			
Internist			
Cardiologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Therapist			
Nutritionist			
Other (Specify)			

PERSONAL STATEMENT: (*In your own words please write a summary of how obesity has impacted your life in the past and how weight loss surgery will impact your life in the future***)**

Please use additional pages as needed