CENTER FOR WEIGHT LOSS SURGERY

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Comprehensive Patient History

PERSONAL INFORMATION

Name: _____/_____/_____ Date of Birth (DOB): _____ Gender: _____
First MI Last

Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Cell Phone: _____ Home Phone: _____ Work Phone (if ok to contact): _____

Patient Email: _____

Ethnicity (optional): ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other: _____

Patient Occupation: _____ Employer: _____ ☐ Full Time ☐ Part Time

Support Person Name: _____ Relationship: _____

Support Person Phone: _____ Support Person Email (if ok to contact): _____

PRIMARY Insurance: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____

Group #: _____ Ins. Phone: _____

SECONDARY Insurance: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____

Group #: _____ Ins. Phone: _____

HEALTH CARE PROVIDER

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Day of Surgery Information:

Person to contact: _____ Relationship: _____ Phone: _____

▶ **Current Weight**: _____ lbs **Height**: _____

Service(s) interested in:

Cosmetic surgery:

☐ Tummy Tuck

☐ Lower Body Lift

☐ Arm Lift

☐ Breast Augmentation

☐ Breast Lift

☐ Liposuction. Specify area(s): _____

☐ Fat Transfer. Specify area(s): _____

☐ Brazilian Butt Lift

☐ Inner Thigh Lift

☐ Other: _____

▶ **Have you had prior weight loss surgery?** ☐ **Yes** ☐ **No**

If yes:

Type of weight loss surgery: _____ Date of surgery: _____

Weight before surgery: _____ lbs.

Patient Name: _____

MEDICAL HISTORY

If you **currently have**, or you **have had** problems with any of the following conditions, indicate how long it has been a problem and if you have had a clinician diagnose and/or treat the problem. Please check (✔) EVERY box YES or NO

RESPIRATORY	**How Long?**	**Diagnosed?**	**Treatment?**
Shortness of breath on exertion	_____	☐ Yes ☐ No	☐ Yes ☐ No
Sleep apnea	_____	☐ Yes ☐ No	☐ Yes ☐ No
Do you use a CPAP/Auto-PAP/ BiPAP	_____	☐ Yes ☐ No	☐ Yes ☐ No Pressure setting: ____- ____
Do you sleep sitting up?	_____	☐ Yes ☐ No	
Asthma	_____	☐ Yes ☐ No	☐ Yes ☐ No

CARDIOVASCULAR	**How Long?**	**Diagnosed?**	**Treatment?**
Heart Attack	_____	☐ Yes ☐ No	☐ Yes ☐ No
Angina – Chest pain	_____	☐ Yes ☐ No	☐ Yes ☐ No
Coronary Artery Disease	_____	☐ Yes ☐ No	☐ Yes ☐ No
Heart Valve Disease	_____	☐ Yes ☐ No	☐ Yes ☐ No
Heart Failure	_____	☐ Yes ☐ No	☐ Yes ☐ No
Enlarged Heart	_____	☐ Yes ☐ No	☐ Yes ☐ No
Cardiomyopathy	_____	☐ Yes ☐ No	☐ Yes ☐ No
Heart Rhythm Abnormality:			
Atrial Fibrillation	_____	☐ Yes ☐ No	☐ Yes ☐ No
Ventricular Fibrillation	_____	☐ Yes ☐ No	☐ Yes ☐ No
Supra - Ventricular Tachycardia (SVT)	_____	☐ Yes ☐ No	☐ Yes ☐ No
Auto Implanted Cardiac Defibrillator (AICD)	_____	☐ Yes ☐ No	☐ Yes ☐ No
Pacemaker	_____	☐ Yes ☐ No	☐ Yes ☐ No
Hypertension	_____	☐ Yes ☐ No	☐ Yes ☐ No

NEUROLOGIC			
Stroke	_____	☐ Yes ☐ No	☐ Yes ☐ No
TIA-Transient Ischemic Attacks/ Temporary Blindness	_____	☐ Yes ☐ No	☐ Yes ☐ No

VENUS THROMBO EMBOLIC DISEASE	**How Long?**	**Diagnosed?**	**Treatment?**
Deep Vein Thrombosis (DVT)	_____	☐ Yes ☐ No	☐ Yes ☐ No
☐ Left leg ☐ Right leg ☐ Both legs			
Pulmonary Embolism (PE)	_____	☐ Yes ☐ No	☐ Yes ☐ No

ENDOCRINE			
Diabetes Mellitus	_____	☐ Yes ☐ No	☐ Yes ☐ No
On insulin?	☐ Yes ☐ No		
Diabetes complications	☐ Yes ☐ No	Specify: _____	
Thyroid disease	_____	☐ Yes ☐ No	☐ Yes ☐ No
Elevated Cholesterol/ Triglycerides	_____	☐ Yes ☐ No	☐ Yes ☐ No

Patient Name: _____

VENOUS

Swelling of the ankles or legs	_____	☐ Yes ☐ No	☐ Yes ☐ No
Venous Stasis Ulcers/Pigmentation	_____	☐ Yes ☐ No	☐ Yes ☐ No

GASTROINTESTINAL

Heartburn	_____	☐ Yes ☐ No	☐ Yes ☐ No
Reflux	_____	☐ Yes ☐ No	☐ Yes ☐ No
Upper abdominal pain	☐ Yes ☐ No	Details: _____	

MUSCULOSKELETAL

Arthritis	☐ Yes ☐ No	
Low back pain	☐ Yes ☐ No	
Joint pain	☐ Yes ☐ No	If yes, specify area: _____
Carpal Tunnel Syndrome	☐ Yes ☐ No	Right ☐ Left ☐ Both ☐

SKIN

Rash under breasts, abdominal folds, groin ☐ Yes ☐ No

REVIEW OF SYSTEMS (Please answer every question by checking (✔) each box.

Constitutional:
Fatigue ☐ Yes ☐ No

Eyes:
Night blindness ☐ Yes ☐ No
Recent change in vision ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No

Nose, Throat, Mouth:
Bloody nose ☐ Yes ☐ No
Dental problems ☐ Yes ☐ No

Cardiovascular:
Low Blood Pressure ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Palpitation ☐ Yes ☐ No
Fainting spells ☐ Yes ☐ No
Rheumatic fever ☐ Yes ☐ No
Peripheral Vascular Disease ☐ Yes ☐ No

Respiratory:
Chronic cough (over 3 mos) ☐ Yes ☐ No
Covid-19 ☐ Yes ☐ No
COPD ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

Gastrointestinal:
Abdominal pain ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No
Early satiety or fullness ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Bloody stools ☐ Yes ☐ No

Liver Disease:
Hepatitis (B or C) ☐ Yes ☐ No
Cirrhosis ☐ Yes ☐ No
Fatty Liver ☐ Yes ☐ No

Genitourinary:
Blood in urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Kidney failure ☐ Yes ☐ No
Urinary incontinence ☐ Yes ☐ No

Genitourinary—Men:
Testicular Pain ☐ Yes ☐ No
Testicular Swelling ☐ Yes ☐ No
Prostate enlargement ☐ Yes ☐ No

Genitourinary—Women:
Are you pregnant? ☐ Yes ☐ No
Menopausal ☐ Yes ☐ No
Hormone replacement therapy ☐ Yes ☐ No
PCOS ☐ Yes ☐ No

Breast:
Breast cancer ☐ Yes ☐ No
Breast lumps ☐ Yes ☐ No

Musculoskeletal:
Sciatica ☐ Yes ☐ No
Right ☐ Left ☐
Osteoporosis ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Rheumatoid arthritis ☐ Yes ☐ No
Difficulty healing incision ☐ Yes ☐ No

Endocrine:
Pituitary problems ☐ Yes ☐ No
Adrenal problems ☐ Yes ☐ No

Blood:
History excessive bleeding ☐ Yes ☐ No

Neurological:
Light headedness ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Memory loss ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Imbalance/unsteady gait ☐ Yes ☐ No
Upper extremity numbness ☐ Yes ☐ No
Migraine headaches ☐ Yes ☐ No
Tension headaches ☐ Yes ☐ No
Concussion ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Bell's Palsy ☐ Yes ☐ No

Diagnosed with:
Anemia ☐ Yes ☐ No
Sickle Cell Disease ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Christmas Disease ☐ Yes ☐ No
von Willebrand Disease ☐ Yes ☐ No
Thrombocytopenia ☐ Yes ☐ No
Protein C deficiency ☐ Yes ☐ No
Protein S deficiency ☐ Yes ☐ No
Infectious mononucleosis ☐ Yes ☐ No
Factor V Leiden deficiency ☐ Yes ☐ No
Thrombocytosis ☐ Yes ☐ No

Patient Name: _____

Diarrhea	☐ Yes ☐ No	Ehlers-Danlos syndrome	☐ Yes ☐ No	Polycythemia	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Marfan's syndrome	☐ Yes ☐ No	Porphyria	☐ Yes ☐ No
Barrett's Esophagus	☐ Yes ☐ No			Hemochromatosis	☐ Yes ☐ No
Hiatal hernia	☐ Yes ☐ No	**Integumentary:**		Leukemia	☐ Yes ☐ No
Gastric Ulcer	☐ Yes ☐ No	Keloid	☐ Yes ☐ No	Lymphoma	☐ Yes ☐ No
Duodenal Ulcer	☐ Yes ☐ No	Difficulty healing incisions	☐ Yes ☐ No	Thalassemia	☐ Yes ☐ No
Gallstones	☐ Yes ☐ No	Melanoma	☐ Yes ☐ No	HIV positive	☐ Yes ☐ No
Pancreatitis	☐ Yes ☐ No	Other skin cancer	☐ Yes ☐ No	History of cancer	☐ Yes ☐ No
Crohn's Disease	☐ Yes ☐ No	Scleroderma	☐ Yes ☐ No	Details: _____	
Celiac Sprue	☐ Yes ☐ No	Lupus	☐ Yes ☐ No		
Ulcerative Colitis	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No	**Injuries to:**	
Colitis	☐ Yes ☐ No	Erythema Nodosum	☐ Yes ☐ No	History of significant injury	☐ Yes ☐ No
Spastic Colon	☐ Yes ☐ No	Herpes Zoster	☐ Yes ☐ No	Specify Areas: _____	
Irritable Bowel Syndrome	☐ Yes ☐ No	Where?: _____		_____	
Hemorrhoids	☐ Yes ☐ No	Post Herpetic Neuralgia	☐ Yes ☐ No		
Colon Polyps	☐ Yes ☐ No				
Colon Cancer	☐ Yes ☐ No	**Psychiatric:**			
		Bi-Polar	☐ Yes ☐ No		
		Depression	☐ Yes ☐ No		
		Anxiety	☐ Yes ☐ No		

ALLERGIES

Are you allergic to any of the following?

Latex: ☐ Yes ☐ No **Surgical Tape**: ☐ Yes ☐ No **X-Ray Dye:** ☐ Yes ☐ No **Iodine**: ☐ Yes ☐ No

▶ **List ALL medications, including over-the-counter (OTC) medications, and food(s) that you are ALLERGIC to:**

_____

_____

Specify what type of reaction: ☐ Difficulty Breathing ☐ Rash ☐ Nausea ☐ Itching ☐ Other: _____

CURRENT MEDICATIONS

List all medications including herbal supplements, homeopathic medications, dietary and weight loss supplements and over the counter medications (such as aspirin). Check medical containers for the correct dosage information.

Name of Medication	Strength	Frequency	Purpose	Start Date	Prescribing Physician

▶ Have you taken steroids? ☐ Yes ☐ No

▶ Are you current with the following immunizations? Tetanus ☐ Yes ☐ No

▶ Are you taking blood thinners (Coumadin, Xarelto, Eliquis) ☐ Yes ☐ No

▶ Are you taking PLAVIX®? ☐ Yes ☐ No

▶ Have you or are you currently taking immunosuppressants? ☐ Yes ☐ No

▶ Are you taking vitamin E or fish oil? ☐ Yes ☐ No

▶ Are you taking GLP-1s (Ozempic, Wegovy, Mounjaro, Zepbound) ☐ Yes ☐ No

Patient Name: _____

SURGICAL HISTORY

▶ **It is important that you <u>complete</u> this for any surgeries you may have had in the past.**

Surgery	Date	Procedure (Open)	Procedure (Laparoscopic)	Surgeon	Reason for Surgery

HISTORY OF RADIATION

Have you had radiation treatment: ☐ Yes ☐ No If yes, specify area(s): _____

Have you had chemotherapy? ☐ Yes ☐ No If yes, specify: _____

ANESTHESIA SCREEN

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Have your family member(s) had problems with anesthesia? ☐ Yes ☐ No

If yes, specify: _____

PAST MEDICAL STUDIES

Have you ever had any of the following tests?

	Normal	Abnormal	Details:
Cardiac Test	☐	☐	_____
Mammogram	☐	☐	_____
Breast Biopsy	☐	☐	_____
Colonoscopy	☐	☐	_____
Other: _____	☐	☐	_____

FAMILY HISTORY

Family Member Chart
Mother (**M**)
Father (**F**)
Brother (**B**)
Sister (**S**)
Maternal Grandmother (**MGM**)
Maternal Grandfather (**MGF**)
Paternal Grandmother (**PGM**)
Paternal Grandfather (**PGF**)

Using the letters in parenthesis from the Family Member Chart, indicate on the line next to the conditions written below which family members have had:

Obesity: _____

DVT or Pulmonary Embolism: _____

Heart Attack: _____

Cancer: _____

Diabetes: _____

SOCIAL HISTORY

▶ **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Significant Other

▶ **Tobacco**: Have you used tobacco products in the past? ☐ Yes ☐ No Year Quit: _____

Tobacco used now? ☐ Yes ☐ No

Patient Name: _____

▶ **Alcohol**: Do you drink alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____

▶ **Drugs**:

Current or past use of recreational / street drugs? ☐ Yes ☐ No If yes, details: _____

Have you ever been enrolled in a drug treatment program: ☐ Yes ☐ No If yes, when? _____

▶ **Activity Level**:

Do you exercise routinely? ☐ Yes ☐ No

If yes, provide details: _____

Can you walk up two flights of stairs without getting short of breath or chest pain? ☐ Yes ☐ No

Can you walk at least 4 city blocks (0.4 miles or 7 times the length of a football field) carrying a bag of groceries without getting short of breath or chest pain? ☐ Yes ☐ No

▶ **Other Comments**:

PATIENT STATEMENT:

I have answered all of the questions to the best of my ability and declare that I am not withholding any information which could be detrimental to my health or well-being, or impact the outcome of my medical treatment.

_____ _____

Patient Signature Date