Patient Weight Loss & Medical History Questionnaire

NAME: ____ Sex: M F Age: ________________

DOB: ______________ Home Phone:_______________________ Work Phone: __________

Current Weight: _________ Current Height _________ BMI _______

INSURANCE INFORMATION

Insurance Name: ____

Does your Health Insurance cover weight loss surgery ? ____________

If so what Pre-Approval Requirements do they have ?

Pre-Op Weight Loss ? ______ lbs

Medically Supervised Weight Loss Program Required _______, Length of time required _____

Duration of Obesity ? ________________________ Smoking cessation ? ________________

Mental Health Clearance ? __________________ Psychological or IQ testing ? _____________

Other Requirements ? ____

PREVIOUS ATTEMPTS AT WEIGHT REDUCTION:

How many years have you been overweight? ________________

Please estimate your weight at the following times:

Birth: _____________

Marriage: _____________

Lowest Weight in Past 5 Years: _____________

Highest Weight in Past 5 Years: _____________

1st Pregnancy - year ________ start weight __________ weight at delivery ______

2nd Pregnancy - year ________ start weight __________ weight at delivery ______

3rd Pregnancy - year ________ start weight __________ weight at delivery ______

4th Pregnancy - year ________ start weight __________ weight at delivery ______

FOOD PREFERENCES

Rate the following foods from 1 - 5. 1 for don’t like very much and 5 for like very much (most likely to make you go off a diet)

_____ soda/soft drinks _____ French fries _____ chips/salty snacks
_____ steaks/chops _____ candy _____ potatoes
_____ chocolate _____ pasta _____ cookies
_____ pizza _____ cakes/pies _____ salad dressings
_____ fried foods _____ bread

____ ________________

Physician's signature Date

NAME: ____

DIET PROGRAMS AND SUPPLEMENTS

Please indicate which of the following diets or plans you have tried:

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
_____ Weight Watchers				
_____ Jenny Craig				
_____ Metabolife				
_____ Medifast				
_____ Nutri/System				
_____ Atkins Diet				
_____ Herbalife				
_____ SlimFast				
_____ Grapefruit Diet				
_____ Liquid Diet				
_____ Pritikin Diet				
_____ Optifast				
_____ T.O.P.S				

List any other physicians - supervised Weight loss attempts: ____________________________________

WEIGHT-LOSS MEDICATION HISOTRY

Please indicate if you have taken any of the following medications to lose weight

MEDICATION	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
_____ Amphetamines				
_____ Phentermine (Adipex, Fastin, Pondimen)				
_____ Phen-Fen				
_____ Dexfenfluramine (Redux)				
_____ Xenical (Orlistat)				
_____ Meridia) (Sibutramine				
Other Diet Medications:				

____ ____________________

Physician's signature Date

NAME: ____

NON-DIETARY THERAPY: Please indicate if you have tried any of the following weight loss therapies.

THERAPY	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
_____ Exercise				
_____ Hypnosis				
_____ Behavior Modification				
_____ Acupuncture				

List any other weight loss methods you have tried: ____

PREVIOUS WEIGHT LOSS SURGERY: ☐Yes ☐No

Surgery	Type	Date	Surgeon	Wt. Loss

____ Physician's signature

_________________ Date