Today's Date:

UC Health Weight Loss Center

www.uchealth.com/weightloss

7690 Discovery Drive, Suite 1700
West Chester, OH 45069

Phone: 513-939-2263
Fax: 513-475-8880

Please note: ALL questions must be completed before returning to the Weight Loss Center. Thank you.

PATIENT INFORMATION

PATIENT MEDICAL HISTORY

Height: _____ Weight: _____ BMI: _____

Last Name: _____ First Name: _____ Middle: _____Mr. Miss. Mrs. Ms.

Hearing impaired? Yes No Visually impaired? Yes No Other limitations? _____

Medical transport required? Yes No Interpreter? Yes No Language: _____

Marital Status (*optional*)? Single Married Partner Divorced Widowed Other _____

Former name: _____ Birth Date: _____ Age: _____ Sex: Male Female

Street Address: _____ City: _____ St.: ____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____ *(circle preference)*

E-mail Address: _____

REQUIRED INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's name: _____ Member ID# _____

Phone # for Providers: _____ Subscriber's S.S.#: _____

Occupation: _____ Employer: _____

Patient's relationship to subscriber: Self Spouse Parent

Name of secondary insurance (if applicable): _____

Subscriber's name: _____ Member ID#: _____

Phone # for Providers: _____ Subscriber's S.S. #: _____

PROGRAM INFORMATION

Seminar date: _____

How did you hear about us? (Please circle): Physician Referral Insurance Family/Friend

TV Internet Social Media (*FB, Twitter, etc.*) Brochure/Flyer Radio Mail E-mail

Other: _____

I am interested in: Non-Surgical Medical Weight Loss Returning to Non-Surgical Medical Weight Loss

Surgical Weight Loss (please choose a surgical procedure you are interested in if known)

- Gastric Sleeve Surgery
- Gastric Balloon Surgery
- Gastric Band Surgery (LapBand)
- Gastric Bypass Surgery
- Revision (explain): _____

Are you currently waiting on a transplant (liver, kidney, lung or heart)? Yes No

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PROVIDER INFORMATION

Primary Care Provider			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Cardiologist			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Pulmonologist			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Psychological Services			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Other Specialist			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

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Past/Present Medical History

(Please circle the appropriate response)

Diabetes	yes	no	past	present	Emphysema/COPD	yes	no	past	present
Age at onset of diabetes: _____					Pneumonia	yes	no	past	present
If yes to diabetes, Diabetes control	good	poor	past	present	Arthritis	yes	no	past	present
Type I Diabetes	yes	no	past	present	If yes to arthritis, where:	yes	no	past	present
Type II Diabetes	yes	no	past	present	_____				
Diabetes while pregnant	yes	no	past	present	Problems with anesthesia	yes	no	past	present
Hypertension (high blood pressure)	yes	no	past	present	Thrombophlebitis	yes	no	past	present
High cholesterol or triglycerides	yes	no	past	present	Abnormal Bleeding	yes	no	past	present
Heart attack	yes	no	past	present	Rheumatic fever	yes	no	past	present
Have pacemaker or defibrillator	yes	no	past	present	Thyroid problems	yes	no	past	present
Congestive heart failure	yes	no	past	Present	Tuberculosis	yes	no	past	present
Coronary heart disease	yes	no	past	present	Urinary tract infections	yes	no	past	present
Heart murmur	yes	no	past	present	Kidney disease	yes	no	past	present
Ever taken Fen-Phen	yes	no	past	present	Bladder/kidney infections	yes	no	past	present
Varicose Veins	yes	no	past	present	Hepatitis/cirrhosis	yes	no	past	present
Blood clots in the legs	yes	no	past	present	AIDS/HIV	yes	no	past	present
Blood clots lungs/Pulmonary embolism	yes	no	past	present	Take antibiotics for dental work	yes	no	past	present
PCOS (Polycystic ovarian syndrome)	yes	no	past	present	Colitis/enteritis/Crohn's Disease	yes	no	past	present
Stroke	yes	no	past	present	Seizures	yes	no	past	present
Asthma	yes	no	past	present					

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Sleep History

Hours sleep per night: _____

Diagnosed with Sleep Apnea	yes	no	If Yes, When?_____		
Actively using oral appliance for mild sleep apnea?	yes	no			
CPAP/BIPAP prescribed	yes	no	Actively using CPAP/BIPAP	yes	no
Frequent waking at night?	yes	no	Aspiration/choking at night?	yes	no
Number of pillows used: _____			Tired, fatigued, or sleepy during the day?	yes	no

Sleep Apnea Questionnaire

Collar size of shirt: S, M, L, XL, or _____ inches/cm

1. Do you snore loudly (louder than talking or loud enough to hear through closed doors? yes no
2. Do you often feel tired, fatigued, or sleepy during daytime? yes no
3. Has anyone observed you stop breathing during your sleep? yes no
4. Neck circumference greater than 17 in? yes no

Surgical History

Previous Weight Loss Surgery (Include year of surgery)			
Gastric bypass (RNY or other)		Gastric band	
Stomach stapling		Sleeve Gastrectomy	
Vertical Banded Gastroplasty		Other	
Other Past Surgical History (Include year of surgery)			
Past Hospitalizations (Include year)			

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Medications

List all daily medications including over-the-counter (aspirin, ibuprofen, Aleve, allergy medications, etc.), vitamins, herbs or supplements, and contraceptives. ***Please indicate NONE if no medications taken****.*

Name	Dosage	Frequency	Reason

Specific Weight Loss Medications – Check all that apply

Medication	✓	Medication	✓	Medication	✓	Medication	✓
Acutrim		Dexatrim		Mazanor		Pondimin	
Adepex-P		Didrex		Meridia		Redux	
Alli		Fastin		Metabolife		Sanorex	
Amphetamines		Fenfluramine		Obalan		Tenuate	
Anorex		Qsymia		Orlistat		Wehless	
Belviq		Herbal Remedies		Phentermine		Xenical	
Benzphetamin		Ionamin		Phenfen		Other	
Contrave		Liraglutide		Plegine		Other	

Do you take any of the following over-the-counter medications regularly?

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	no

Allergies

List any known food or medication allergies or sensitivities ***– please indicate NONE if no medications taken***

Allergy	Reaction

List any allergies or sensitivities to the following:

Substance			Reaction	Substance			Reaction
Latex	yes	no		Iodine	yes	no	
Dye	yes	no		Tape	yes	no	

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Psychiatric

Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential.

Please check all that apply.

- ☐ Alcoholism / Substance abuse
- ☐ Anorexia
- ☐ Anxiety
- ☐ Attempted suicide
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Binge eating disorder
- ☐ Bipolar disorder ('manic- depression') type 1 or type 2
- ☐ Bulimia
- ☐ Depression
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia/Schizoaffective Disorder
- ☐ Sexual abuse (if yes, when _____)
- ☐ Mental/Emotional abuse (if yes, when _____)
- ☐ Physical abuse (if yes, when _____)
- ☐ Self injury or cutting behavior (if yes, when _____)
- ☐ Other psychiatric illness or condition? Please describe here: _____

Have you ever had outpatient psychiatric counseling?
Yes ☐ No ☐ If yes, for what condition(s)?
_____

Have you ever been hospitalized for psychiatric problems?
Yes ☐ No ☐ If yes, when?
_____

Are you currently seeing a counselor/psychiatric professional?
Yes ☐ No ☐ If yes, for what condition(s)?
_____

Have you ever been in an alcohol or substance abuse program?
Yes ☐ No ☐ If yes, from: _____ to: _____

Are you currently taking medications for anxiety ('nerves'), depression or other mental health problems?
Yes ☐ No ☐

If yes, who is your prescriber? Name: _____
Address: _____
Phone: _____

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Social History

Religious Preference: _____
Ethnic background: _____

Please circle the appropriate response:

Do you currently smoke? yes no
Have you ever smoked? yes no Age started _____ Age last smoked _____ Avg. # cigarettes/day _____
Do you drink alcohol? yes no **If yes**, number of drinks per week? ____
(*drink = 1 shot, 1 glass of wine, 1 beer or 1 cocktail)*
Do you use marijuana? yes no How often _____
Do you use recreational drugs yes no **If yes**, what _____ How often _____
Do you abuse prescription drugs? Yes no **If yes**, what _____ How often _____

On a scale of 1-10 how motivated, are you to change your lifestyle? _____ (10=highly motivated)
How does your spouse, partner, family, friends, and significant others feel about your weight issues? _____
_____
_____

Weight History

Age you first became overweight _____
Highest adult weight (age 25 and older) _____ lbs.
Weight comfortably maintained _____ lbs.
Lowest adult weight (age 25 and older) _____ lbs.

Please check all that apply:

Grew up:
- ☐ overweight
- ☐ normal
- ☐ active in
- ☐ under weight
- ☐ average

Weight gain after:
- ☐ moved
- ☐ marriage
- ☐ divorce
- ☐ separation
- ☐ quit smoking
- ☐ aging
- ☐ desk job
- ☐ injury
- ☐ gradual
- ☐ surgery

Exercise History

Please place a check in the appropriate box:

Do you track and/or monitor your activity? yes ☐ no ☐ How? (Fitbit, pedometer) _____

Do you exercise on a regular basis? yes ☐ no ☐

Are you able to perform exercises such as walking 3 blocks, swimming or using exercise bike? yes ☐ no ☐

Average time spent exercising:	**I don't do this**	**1x/week**	**2-3x/week**	**4-5x/week**	**6+x/week**	**Minutes/day**
Walking						
Stretching Exercise (yoga, bands, etc.)						
Weight Lifting						
Aerobic						
Other: _____						

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Family Medical History:

Please indicate if you have a family history of the following:

Are you adopted? Yes No

Parent(s): **Mother** ☐ alive ☐ deceased **Father** ☐ alive ☐ deceased

Sibling(s): **Brother(s):** How many alive? ___ How many deceased? ___ **Sister(s):** How many alive? ___ How many

Children: How many alive? ___ How many deceased? ___

Please complete the below section if <u>NOT</u> adopted.

	Parent(s)		**Sibling(s)**		**Other Relatives**		
	Mother	*Father*	*Brother*	*Sister*	*cousins, aunts, grandparents, etc.*	**No Family History**	**Don't Know**
Diabetes							
Heart Disease							
Hypertension							
Gallstones							
Obesity							
Sleep Apnea							
Asthma							
Cancer *(specify type)*							
Depression							
High Cholesterol							
Osteoporosis							
Stroke							
Chemical Dependency							
Alcohol Abuse							
Bipolar disorder							
Anesthesia Problems							
Schizophrenia							

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Nutrition History

Do you track and/or monitor your calories or food intake? yes no
If yes, what do you use? (examples: MyFitnessPal, Spark People, etc.) _____
How often do you track calories or food intake? ☐ Daily ☐ 2 – 3 times a week ☐ 1 time a week or less
How many meals do you eat daily? _____
Do you snack between meals? yes
no
Are you able to make your own food choices and control your food environment? yes no

Food Frequency

Estimated servings per day:	0-3 per day	3-6 per day	6-9 per day	10+ per day
Soda/sugary drinks/sweet tea/lemonade				
Sweets/deserts/candy				
Fried foods/fast food/chips/pizza				
Dairy products/cheese/etc.				
Carbs/breads/cereal/pasta				
Fruits/veggies				
Proteins				

Eating Behaviors

Chaotic eating patterns/not eating regular meal yes ☐ no ☐

Sleepwalking & eating yes ☐ no ☐

(such as waking up to see evidence of food consumed with no memory of having eaten it.)

Drinking sweetened beverages – pop, kool-aid, etc. yes ☐ no ☐

Emotional/stress eating yes ☐ no ☐

Preference snacking on:

pretzels, chips, starches yes ☐ no ☐

sweets yes ☐ no ☐

large portion sizes yes ☐ no ☐

Other Weight Gain Contributing Factors

Decrease in activity after job change yes ☐ no ☐

Decreased activity after an injury yes ☐ no ☐

Genetics yes ☐ no ☐

Medications yes ☐ no ☐

Smoking cessation yes ☐ no ☐

Weight gain with pregnancy yes ☐ no ☐

Yo-yo dieting yes ☐ no ☐