

Name:

Date:

High Cholesterol (abnormal lipids)	Yes	No	
Heart Disease or Previous Heart Attack	Yes	No	
Asthma	Yes	No	
Arthritis	Yes	No	
Back Pain	Yes	No	
Legs ulcer or Reddish-brown legs	Yes	No	
Depression	Yes	No	
COPD (Chronic Obstructive Pulmonary Disease)	Yes	No	
Severe symptoms:		Yes	No
History of hospitalization due to COPD:		Yes	No
Pulmonary Embolism (blood clot in lungs)	Yes	No	
DVT (blood clot in legs)	Yes	No	
Stroke	Yes	No	
Gallstones/ Gallbladder disorder	Yes	No	
Polycystic Ovarian Syndrome	Yes	No	
Bleeding disorder	Yes	No	
Liver disorder	Yes	No	
Kidney disorder	Yes	No	
Thyroid disorder	Yes	No	
Seizure	Yes	No	
Use of scooter, wheelchair, or other device to move around	Yes	No	
Activities of daily living	Independent	Dependent (Total or Partial)	
Requiring oxygen:		Yes	No
Obstructive Sleep Apnea	Yes	No	
Sleep study done:		Yes	No
CPAP required:		Yes	No

High Risk of Sleep Apnea (STOP-Bang Score)

1. Do you snore loudly (louder than talking or loud enough to be heard 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. Do you have or are you being treated for high blood pressure?	Yes	No

Any Other Medical History- Please list ALL other medical history

FAMILY HISTORY – Please mark “x” to all that apply

Family member	Obesity	Diabetes	Heart disease	High Blood Pressure	High Cholesterol	Cancer (indicate type)
Father						
Mother						
Grand parents						

Do you or any of your family members have a history of a **bleeding or clotting disorder**? Yes / No

Please list: _____

Weight Loss History

How long have you been at your present weight? _____ yrs

What did you weigh 5 years ago? _____ lbs

What is the most you have ever weighed in your adult life? _____ lbs The least weight? _____ lbs

Name:

Date:

Has a physician ever supervised your attempts to lose weight? Yes / No

Doctor/Clinic

City:

Treatment Dates:

Type of Treatment:

Have you tried diet pills? Yes / No

If yes, please list: _____

Please check all that you have tried **IN THE LAST 10 YEARS.**

	Year	Weight Loss (lbs)		Year	Weight Loss (lbs)
Atkins			Medifast		
Acupuncture			Nutrisystem		
Calorie Counting			Nutritionist		
Diet Center			Optifast		
Fad Diet			Overeaters Anonymous		
Herbal Diet			Pritikin		
Health Spa			Self Diet		
High Protein			Slim Fast		
Hypnosis			Start Fresh		
Jenny Craig			South Beach		
LA Diet			Weight Watchers		
Leder			Zone		
Low Carbohydrate					

Patient Signature: _____ **Date:** _____

MD Reviewed: _____ **Date:** _____