



<b>Name</b>		
<b>Email Address</b>		
<b>Phone (with Area Code)</b>		
Cell Phone (with Area Code)		
<b>Address</b>		
<b>Billing Address</b>		
Sex		
Age		
Height		
Current Weight		
Birth Date		
SSN		
Driver's License (State, No.)		
Race		
Marital Status		
How many children do you have?	Ages	
Lifetime maximum weight		
Age at which you first became 75 lbs. or more overweight		
How do you now perceive your body weight?		
How do you believe that others perceive your body weight?		
Number of weight loss methods tried pre-op	(please provide a number even if you are unsure of the total)	
How many times have you lost 20 or more pounds?	(answer with a number even if it is only a guess)	
Main reason for wanting treatment for weight loss?		
<b>INSURANCE</b>		
Insurance carriers		
Insurance plans		
<b>Company Name</b>	PRIMARY	SECONDARY
<b>Company Address</b>		
<b>Company Phone</b>		
<b>Insured's Name</b>		
<b>Insured's Policy Number</b>		
Insured's Group Number		

**EMPLOYMENT**

Are you employed?	
Employer name	
Employer phone	
Employer address	
Type of work	

**FAMILY PHYSICIAN**

<b>Physician Name</b>	
<b>Physician Address</b>	
<b>Physician Phone</b>	

**FAMILY HISTORY**

Counting yourself, your full brothers and sisters, and your parents, how many people are in your immediate family?	
How many people in your immediate family (yourself included) were at one time or another 75 lbs. or more overweight?	
Has any blood relative ever had a problem with Anesthetics (e.g. malignant hyperthermia)	

**DOES ANYONE IN YOUR FAMILY HAVE...**

...Diabetes?		Relation:
...High blood pressure?		Relation:
...Heart disease?		Relation:
...Gallstones?		Relation:

**OPERATIONS**

List all previous operations/ anesthetics	OPERATION	DATE	TYPE OF ANESTHESIA	PROBLEMS (if any)

**ILLNESSES**

List all serious illnesses	
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**MEDICATIONS**

What medications are you taking? [Do not forget such things as aspirin, cortisone, blood pressure medication, thyroid, tranquilizers, hormones, birth control pills, laxatives, vitamins, etc.]	MEDICINE	DOSE	AVERAGE FREQUENCY

Have you ever taken Phen-fen?		If yes, then for how long?
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**ALLERGIES**

Are you allergic to any medications? (If yes, list medications)	MEDICATION		REACTION	
Do you have food allergies?				
Check if you have any of these	Egg/Soy bean allergy	Hives	Hay fever	Childhood Eczema

**EATING HABITS**

Do you eat breakfast?	
Do you snack at night?	
Do you snack during the day?	
Do you drink soda or other very sugary liquids?	
Do you eat desserts?	
Do you eat fried foods?	
Do you binge eat? (Bingeing means that you eat a lot more than you feel you should eat.)	
How large are your meals compared to normal w eight people eating the same meal?	

**SMOKING AND DRINKING**

How many cigarettes (or packs) do you smoke a day?	
Do you drink alcohol?	
Have you ever been in an alcohol rehabilitation program?	

**SLEEPING**

How often do you have restless sleep or frequent aw akening?	
How often do you have night sw eats?	
How often do you snore?	
How often do you have daytime sleepiness?	
How often do you have morning headaches?	
In the past year, has anyone told you that you held your breath for a long time w hile asleep?	
Do you w ake at night with a snort or gasp?	

<b>RESPIRATORY</b>		
Spitting of blood?		
Have you had bronchitis?		
Have you had emphysema?		
Have you been diagnosed or treated for asthma?	If yes, list medications used:	
Year of last chest x-ray?		Was it normal? <b>Yes</b>
<b>CARDIOVASCULAR</b>		
Chest pain or angina pectoris?		
Heart murmur?		
Have you ever had palpitations/ arrhythmia		
Have you had a heart attack?		
Have you been diagnosed or treated for High Blood Pressure?	If yes, list medications used:	
Have you had varicose veins?		
Have you had blood clots or phlebitis (inflammation in the leg veins)?		
Year of last EKG?		Was it normal?
Do you have shortness of breath after climbing one flight of stairs?		
How many blocks can you walk without having to stop for breath?		
How many days a week do you exercise on average?		
<b>GASTROINTESTINAL</b>		
Tarry black stool or blood in bowel movements?		
Crampy abdominal pain?		
Chronic constipation?		
Frequent diarrhea?		
Change in bowel habits?		
Hemorrhoids or piles?		
Have you been diagnosed as having stomach or intestinal ulcers or other disorders of the gastrointestinal system?		
Have you had hepatitis or liver problems?		
Ever vomit blood?		
Do you have heartburn?		

URINARY	
Have you had kidney problems?	
Burning or painful urination?	
Frequent urination?	
Feeling you must go immediately?	
Do you lose small amounts of urine with coughing or straining?	
Blood in urine?	
Kidney stones?	

GYNECOLOGICAL	
Have you had gynecological (female) problems?	
Are you or might you be pregnant?	
Do you experience menstrual difficulties?	

MUSCULOSKELETAL	
Arthritis, swollen or painful joints?	
Pain in calves or buttocks when walking, relieved by rest?	
How often do you have swelling of ankles?	
How often do you have joint pain - back?	
How often do you have joint pain - hip?	
How often do you have joint pain - knee?	
How often do you have joint pain - ankle?	
How often do you have joint pain - foot?	

SKIN	
Frequent infections?	
Unusual moles or lumps?	Describe unusual moles or lumps:

HEAD	
Eye disease or injury?	
Double Vision?	
Headaches?	
Epilepsy or seizures?	
Brain disease or Strokes?	

MENTAL HEALTH			
Are you satisfied with your social life?			
Were you ever severely abused? (check all that apply)	Emotionally	Physically	Sexually

Are you satisfied with your sex life?	
How would you rate your self esteem level?	
How would you rate your energy level?	
Do you have trouble sleeping?	
Are you usually tired?	
Are you often depressed?	
Are you often anxious or nervous?	
Do you ever wish you were dead and away from it all?	
Have you ever seen a psychiatrist?	Name
	Address
	Phone
Have you ever been hospitalized for psychiatric reasons?	

**HEMATOLOGICAL**

Anemia?	<b>Never</b>
Excessive bleeding or abnormal bruising?	<b>Never</b>
Have you ever received a blood transfusion?	<b>Never</b> <span style="float: right;">If yes, in what year?</span>

**ENDOCRINE**

Hormone therapy?	
Thyroid problem?	
Have you been diagnosed or treated for Diabetes?	If yes, list medications used:
Have you been told that you have Gallstones?	

**METHODS OF WEIGHT CONTROL USED IN THE PAST**

Doctor Supervised Programs	TYPE	WHEN	PROGRAM
	Rader Institute		
	Lindora		
	Fasting		
	B-6		
	Amphetamines		
	Opti-Fast		
	Schick Center		
	Medifast		
	HCG Shots		
	B-12		
	Other weight loss pills		
	Other		

Traditional Weight Loss Programs	TYPE	WHEN	PROGRAM
	Jenny Craig		
	Over Eater's Anonymous		
	Weight Watchers		
	Nutri System		
	"Fat Farms"		
	Exercise program		
Other			
Non-traditional Weight Loss Programs	TYPE	WHEN	PROGRAM
	Gastric Bubble		
	Acupuncture		
	Jaw wiring		
	Hypnosis		
Other			
Self Diets	TYPE	WHEN	PROGRAM
	Slim Fast		
	Dieter's tea		
	Accutrim		
	Dexatrim		
	Cal Ban 3000		
	Fasting		
	Other		
Popular Diet Programs	TYPE	WHEN	PROGRAM
	Scarsdale Diet		
	Herbal Life		
	Bahamian Diet		
	Beverly Hills Diet		
	Pritikin Diet		
	Cambridge Diet		
	R. Simmons' Deal-A-Meal		
Other			
Nutritional Programs	TYPE	WHEN	PROGRAM
	In-Hospital		
		Hospital/Clinic Name:	
	Out-Patient		
Hospital/Clinic Name:			
Surgical Weight Loss Procedures	TYPE	WHEN	HOSPITAL/CLINIC NAME
	J.I. Bypass		
	Vertical Band Gastroplasty		
	Vertical Ring		
Roux en Y Gastric Bypass			

**CHOICE OF SURGERY**

**Which surgery are you interested in:**

<b>CHOICE OF SURGEON</b>	
<b>Surgeon Preference?</b>	
<b>PATIENT INFORMATION SEMINAR</b>	
Have you attended a patient information seminar?	Yes I have attended a live seminar I have view ed the online seminar in it's entirety
<b>WHERE DID YOU FIND US?</b>	
I heard about Coastal Obesity from	
Final Comments	