OhioHealth Weight Management.
Surgical. Medical. Weight Loss.

Name of person completing this form: _____

Relationship to the patient: ❒ Self ❒ Spouse ❒ Parent ❒ Other: _____

Do you need help with completing this form? ❒ No ❒ Yes

PATIENT DEMOGRAPHICS

Your Name
Last: _____ First: _____ MI: _____ Date of Birth: ____/_____/_____

How did you hear about us? _____

What is your highest level of education completed?
❒ Did not graduate High School ❒ High School ❒ Some college classes ❒ College Degree ❒ Graduate Degree

What is your preferred language? _____

Do you have any difficulty with hearing?
❒ No ❒ Yes ❒ I use hearing aids

Do you have any visual impairments?
❒ No ❒ Yes ❒ I use glasses/contact lenses

On the scale to the right please rate your overall health by circling the number that best fits you

1 2 3	4 5 6 7	8 9 10
unhealthy/ill	average	very healthy

Mark the statement that best describes your sense of control over your health, life, and happiness.

☐ I feel in control and what happens in my life is largely a result of my actions.
☐ I feel in control of my life most of the time.
☐ I feel my life is often determined by outside influences and circumstances beyond my control
☐ I feel I have little or no control and am unable to change things in my life

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SURGICAL WEIGHT MANAGEMENT (fill out if interested in Bariatric Surgery)

1. Have you ever been enrolled in another bariatric surgery program? ❒ No ❒ Yes

   ➔ **If Yes**, when were you enrolled in the other program? _____

   Name of other program: _____

   Location (city, state): _____

2. Have you had bariatric surgery in the past? ❒ No ❒ Yes

   ➔ **If Yes**, what bariatric surgical procedure did you have? _____

   Date of surgery: _____

   Location (city, state): _____

Procedure or care that you seek from OhioHealth Surgical Weight Management:

- ☐ Gastric Bypass
- ☐ Gastric Sleeve
- ☐ Revisional surgery (prior bariatric surgery)
- ☐ Follow-up care after prior bariatric surgery through another program

YOUR WEIGHT LOSS HISTORY

How tall are you? _____ ft _____ in How much do you weigh now? _____ lbs

At what periods of your life have you been overweight? (please check all that apply)
❒ Childhood (age 12 or under)
❒ Adolescence (ages 13-18)
❒ Young adult (ages 19-29)
❒ Middle adult (ages 30-59)
❒ Older adult (age 60 or greater)

Have specific events ever resulted in your becoming overweight?
❒ No
❒ Yes ➔ What were these? (e.g., illness/injury, inability to lose weight after pregnancy)
_____

Have you ever been 100 pounds or more overweight?
❒ No
❒ Yes ➔ If yes, for how long? _____ years

At what age did you begin dieting? _____ years ❒ I have never gone on a diet

Please check all applicable weight loss methods you have previously tried from the list below:

❒ Calorie counting/restriction
❒ Low fat diet
❒ Atkins' diet
❒ Diabetic diet/ADA
❒ Grapefruit diet
❒ Dr. Oz diet
❒ Hypnosis
❒ Prepared food programs (Nutrisystem, Medifast)
❒ Other(s): _____
❒ High protein/low carbohydrate
❒ Heart Healthy/DASH
❒ South Beach diet
❒ Cabbage soup diet
❒ The Zone diet
❒ Dr. Phil's diet
❒ Weight Watchers
❒ Physicians Weight Loss Centers
❒ Meal replacements (SlimFast, Optifast)
❒ Curves
❒ Mayo Clinic diet
❒ Overeaters Anonymous
❒ Jenny Craig
❒ Cleveland Clinic diet
❒ Herbalife
❒ McConnell Heart Health Center diet

Which over-the-counter or prescribed medications or supplements have you tried specifically for weight loss purposes?

❒ Dexedrine (dextroamphetamine)
❒ Pondimin (fenfluramine)
❒ Fen-Phen ➔ # months _____
❒ Wellbutrin
❒ Xenical/Alli (orlistat)
❒ Metformin
❒ Xenadrine
❒ Green tea extract
❒ Other(s): _____
❒ Redux (dexfenfluramine)
❒ Didrex (benzphetamine)
❒ Phentermine/Adipex
❒ Prozac
❒ Meridia (sibutramine)
❒ HCG
❒ Metabolife
❒ Fastin / Pro-Fast
❒ Diuretics ("water pills")
❒ Byetta / Januvia
❒ Tenuate (diethylproprion)
❒ Accutrim / Dexatrim
❒ Ephedra / Ephedrine
❒ Lipozene / Leptoprim
❒ Laxatives
❒ Hydroxycut
❒ Aydes
❒ Cortislim
❒ Slim Quick
❒ Relacor
❒ Vitamin B_{12} injections
❒ Green coffee bean
❒ Sensa
❒ Trimspa
❒ Hoodia

Did any weight loss methods or medications/supplements help you be successful in losing weight?
❒ None
❒ A little (less than 25% of the weight I wanted to lose)
❒ Fair (25 to 50% of the weight I wanted to lose)
❒ Good (between 50% and 75% of the weight I wanted to lose)
❒ Excellent (lost >75% of the weight I wanted to lose)

How much weight did you lose with your most successful attempt? _____ lbs

If you had at least some success with using a weight loss method or medications/supplements, how long did you keep that weight off?
❒ No success
❒ <3 months
❒ 3-6 months
❒ >6 months up to 1 year
❒ More than 1 year up to 5 years
❒ More than 5 years

What method(s) were involved in this success? _____

What reasons do you feel contribute to your weight problems? (check all that apply)

❒ Lack of knowledge about healthy foods
❒ Surrounded by temptations
❒ Lack of time for physical activity
❒ I don't know how to exercise safely
❒ Hormonal (menopause, hysterectomy, thyroid)
❒ Exercise equipment/gym membership too costly
❒ Poor food and beverage choices
❒ Lack of time for healthy food preparation
❒ I don't like the taste of healthy foods
❒ My health status prevents physical activity
Might be nice to group by diet and exercise
❒ It hasn't been a priority for me
❒ Medications I am taking
❒ Healthy foods cost too much
❒ I don't like to exercise

BEHAVIORAL HEALTH AND SOCIAL HISTORY

Smoking History

1. Check the box that most accurately describes your tobacco status
   - ☐ Never smoked
   - ☐ Currently smoke cigarettes
   - ☐ Quit using tobacco more than 1 year ago.
   - ☐ Currently use smokeless tobacco
   - ☐ Quit using tobacco less than or equal to 1 year ago

   Quit date_____ (month/year)

   If you are a current or past tobacco user, which form(s) of tobacco have you used:

   Cigars pipe cigarettes vaping snuff/dip/chew marijuana

   How often and for how many years:

   Year quit:

Alcohol History

1. Check the box that most accurately describes your use of alcohol
   - ☐ Do not drink alcohol at all
   - ☐ Drink alcohol rarely (less than once a month)
   - ☐ Drink alcohol at least once a month, but not every week
   - ☐ Drink alcohol weekly
   - ☐ Drink alcohol nearly every day

2. Did you drink alcohol in the past? ☐ No ☐ Yes

   For how many years? _____
   Year quit _____
   How many times per week? _____
   How many drinks each time? _____

3. If you drink alcohol now, is anyone concerned about the amount you drink?
   ☐ No ☐ Yes ☐ I don't drink alcohol now

4. Were you ever in treatment for alcohol abuse or dependence? ☐ No ☐ Yes

   Was this: ❒ Outpatient ❒ Inpatient ❒ Both inpatient & outpatient

   Approximate date(s): _____

   Was this treatment successful for you? ❒ No ❒ Yes

   Comments? _____

   _____

5. Have you engaged in recreational drug use? No Yes

Prescription, Recreational or "Street" Drug History

1. Do you use prescription drugs that have not been prescribed for you?
   ☐ Yes ☐ No

   If YES what drugs? _____

   For how many years? _____
   How often? _____

2. Do you use recreational or "street" drugs?
   ☐ Yes ☐ No

   If YES what drugs?
   For how many years? _____
   How often? _____

3. Were you ever in treatment for drug abuse or dependence? ☐ No ☐ Yes

   Was this: ❒ Outpatient ❒ Inpatient ❒ Both inpatient & outpatient

   Approximate date(s): _____ Was this treatment successful for you? ❒ No ❒ Yes

Psychological History

1. Have you been diagnosed with any of the following? ❒ No ❒ Yes

   ❒ Depression: Year: _____
   ❒ Anxiety: Year: _____
   ❒ Bipolar: Year: _____
   Substance Dependence
   Binge Eating Disorder
   Bulimia
   ADHD
   PTSD
   Personality Disorder
   Schizophrenia
   ❒ Other psychiatric diagnosis: _____ Year: _____

   Do you have a history of trauma or abuse? No Yes childhood/adult

2. Have you been prescribed medications for this diagnosis / diagnoses? ❒ No ❒ Yes

   Please list with month/year first prescribed:

   Medication #1: _____ Mon/Year: _____

   Medication #2: _____ Mon/Year: _____

   Medication #3: _____ Mon/Year: _____

3. Are you currently taking these medications as prescribed?

   ❒ Not applicable (no medications prescribed for psychiatric diagnoses)
   ❒ Yes
   ❒ No ➔ Why not? _____

   _____

   _____

4. Have you ever had counseling or psychotherapy? ❒ No ❒ Yes
   Was this: ❒ Outpatient ❒ Inpatient ❒ Both inpatient & outpatient

   Reason: _____

   Approximate date(s): _____

5. Have you ever been hospitalized for psychiatric reasons? ❒ No ❒ Yes

   Year of hospitalization(s): _____ Location(s): _____

MEDICATIONS PRESCRIBED TO YOU

Name of Drug	Dose	Times per day	Reason for taking

Over-the-Counter Medications, Vitamins and Supplements

Name	Dose	Times per day	Reason for taking

Do you have any medication allergies or sensitivities? ❒ No ❒ Yes

If yes, list the medication and what happens if you take it:

_____

_____

YOUR FAMILY'S MEDICAL HISTORY

In this table, health problems appear down the left and family members appear in columns to the right of each condition. For each condition, check the appropriate box to the right for each family member who has had that condition. See the example below.

Condition	Father	Mother	Sibling	Grandparent	Other
Example: heart disease	✓			✓	
High blood pressure					
High cholesterol					
Diabetes (adult onset)					
Heart disease / attack					
Angioplasty or stent					
Heart bypass surgery					
Irregular heart beats					
Stroke / TIA					
Asthma					
Blood clots					
Peripheral vascular disease (PVD)					
Lung disease or emphysema					
Obesity					
Sleep apnea					
Osteoarthritis					
GERD / acid reflux					
Gout					
Psychiatric conditions					
Cancer (type):					
Cancer (type):					
Other:					
Other:					

YOUR MEDICAL HISTORY

Surgical Procedure(s) & Year

☐ Gallbladder (open/laparoscopic): _____
☐ Anti-reflux procedure/Nissen fundoplication: _____
☐ Upper GI Endoscopy
☐ Tonsillectomy: _____
☐ Hysterectomy: _____
☐ Ovaries Removed: _____
☐ Other Ovary Surgery/Tubal Ligation: _____
☐ Vasectomy: _____
☐ Bowel Resection:_____
☐ Other: _____

☐ Back (describe): _____
☐ Hernia (type): _____
☐ Appendectomy (open/alp): _____
☐ Neck (describe): _____
☐ Back (describe): _____
☐ Hip (replacement or fixation): _____
☐ Knee (replacement or arthroscopy): _____
☐ Peripheral Vascular Procedure: _____
☐ Heart Surgery: CABG/Other: _____
☐ Breast Biopsy: _____
☐ Breast Lumpectomy/mastectomy: _____

Anesthesia Problems

☐ None ☐ Nausea ☐ Woke up during procedure ☐ Difficulty Urinating ☐ Other: _____
☐ Vomiting ☐ Heart Stopped ☐ Difficulty waking up ☐ Stopped Breathing

(CHECK ALL THAT APPLY)

Review of Systems:

☐ Fevers ☐ Chills/Night Sweats ☐ Hair Loss/Alopecia ☐ Snoring
☐ Insomnia ☐ Appetite Change/Loss ☐ Fatigue/Tired ☐ Unexplained Weight Gain/Loss
☐ Cancer: Type: _____ ☐ Other: _____
☐ Hearing problem/Hearing aid
☐ Blurred/Double Vision ☐ Gum Problems/bleeding ☐ Season Allergies/Hay Fever
☐ Glaucoma/Eye Disease ☐ Vertigo (room spinning)
☐ Cataracts ☐ Blindness
☐High Blood Pressure: ○ Borderline/No medication ○ Single medication ○ multiple medications ○ poorly controlled
☐Poor circulation in legs/Peripheral vascular disease (PVD): ○ medication ○ Surgery/revascularization
☐Deep blood clot in leg (DVT): ○ resolved with anticoagulation ○ Recurrent
☐Blood clot in lungs (pulmonary embolism): ○ resolved with anticoagulation ○ recurrent ○ vena cava (Greenfield) filter placed

☐ Other Cardiovascular ☐ Heart Disease ☐ Atrial Fibrillation/Arrhythmia
☐ Prior Heart Attack ☐ Congestive Heart Failure (CHF) ☐ Ankle Swelling/Edema
☐ Chest pain with activity/Angina ☐ Shortness of breath with exercise ☐ Heart catheterization

☐Diabetes: ○ oral medication only ○ insulin only ○ oral medication and insulin ○ complications (neuropathy/organ)
○ excessive sweating ○ pre diabetes ○ heat or cold intolerance ○ gestational diabetes
○ excessive urination ○ excessive thirst ○ low blood sugar
☐ Elevated Cholesterol/Triglycerides: ○ diet modification ○ single medication ○ multiple medications
☐Under/Over active Thyroid
☐ Asthma: ○ inhaler(s) ○ oral medications ○ not controlled ○ multiple hospitalizations required
☐ Obstructive Sleep Apnea: ○ symptoms but negative or no formal sleep study ○ diagnosed but no appliance
○ CPAP/ BiPAP ○ Shortness of breath at rest

☐ COPD/Emphysema ☐ Other Respiratory

☐ GERD/Heartburn: ○ no medication ○ intermittent medication ○ daily medication ○ prior surgery
☐ Gallbladder Problems/Gallstones: ○ intermittent symptoms ○ gallbladder removal (incision/laparoscopic)
☐ Abnormal Liver findings / Elevated Liver Enzymes: ○ enlarged liver ○ elevated enzymes ○ NASH/fatty liver ○ liver failure
☐ Barrett's esophagus ☐ Polyps ☐ Bile duct disease/blockage
☐ Hiatal hernia ☐ Incisional/Abdominal hernia
☐ Kidney Stones: Treatment including (if applicable): ○ medication ○ prior surgical procedure or lithotripsy (ESWL)
☐ Kidney Failure / Renal Insufficiency: ○ dialysis
☐ Menstrual irregularity: ○ no menses ○ abnormal periods ○ excessively heavy periods ○ menstrual pain
☐ Back Pain: ○ intermittent
☐ Other Joint pain: _____
☐ Stoke/CVA ☐ Headaches ☐ TIA
☐ Anemia (iron deficient) ☐ Anemia (vitamin B12 deficient)☐ Frequent skin infections ☐ Poor wound healing ☐ Skin ulers
☐ Recurrent/chronic rashes/chafing under skin folds
☐ Other: _____