Cheyenne Regional
Medical Center

Weight Loss Center
421 East 17th
Cheyenne WY 82001

PATIENT HISTORY QUESTIONNAIRE

DIRECTIONS:

***The information requested in this questionnaire is extremely important*.**

To give you the best care and to obtain your insurance approval, we must have ***complete*** answers. Please take your time and be thorough. Please put comments on the back of the sheet or a separate piece of paper if necessary.

The details of the following sections are important:

DIETING and EXERCISE HISTORY

- *Your dieting and exercise history is critical to attaining benefits from your insurance company.*
- *Check your facts whenever possible. Cancelled checks, credit card records, doctor's office Notes (call your practitioner), and receipts may be useful. Ask your friends and family to help you remember.*
- *Take your time. It is imperative to be as detailed and accurate as possible.*

WEIGHT RELATED ILLNESSES:

- *Double-check to make sure you have filled out the gray areas of this section.*

MEDICATIONS:

- Please record ***exact dosages*** AND ***intervals*** taken.
- Please check your medication bottles or call your pharmacy to get accurate information recorded on your medications**.**

I am interested in:
Gastric Bypass _____
Lap Band _____
Gastric Sleeve _____
Undecided _____

WEIGHT-LOSS SURGERY INSURANCE FORM

Today's Date:

		M F	M D S W
Last Name, First, Middle Initial	Date of Birth Age	Sex	Marital Status
Street Address	Home Phone Cell Phone Work Phone		
City State Zip	Email Address Race		
Employer's Name	Social Security Number		
	☐ Full time ☐Part time		
Employer's Street Address	Occupation		
City State Zip	Alternate contact (not living with you) Contact Number		
Emergency Contact Contact Number	Alternate Contact Contact Number		
		Y N	
Address Relationship	Religious Preference	Do you Smoke?	

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Group Number	Group Number
Policy or ID Number	Policy or ID Number
Subscribers Name Subscriber DOB	Subscribers Name
Relationship to Patient Subscriber SSN	Relationship to Patient
Subscriber's Employer	Subscriber's Employer

How did you hear about us? (if a newspaper, please specify which one)

____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

Signature: ____ Date: _________________

INITIAL PATIENT HISTORY FORM

Referring Physician / Practitioner:	Name: City: State: ☐ Self-Referred		
Primary Care Physician / Practitioner:	Name: City: State: ☐ None		
Please list other physicians/practitioners whose care you are under (internists, OB/GYN, Cardiologist, endocrinologist, psychiatrist, pulmonologist, etc)	Name: Specialty: Name: Specialty: Name: Specialty: Name: Specialty:		
Current Weight: lbs	Current Height: feet inches		
This entire gray section is for office purposes only	***Office Measurements and Calculations*** ***Date:***		
Today's Weight ______________lbs Ideal Body Weight ____________lbs	Ht: ________feet ________inches Excess Body Weight: ________lbs	**BMI:**	>35 ☐ Severe obesity >40 ☐ Morbidly obese >50 ☐ Super obese
Percent Ideal Body Weight________%	80% of Excess Wt. =	Estimated Goal Wt: __________________lbs.	

WEIGHT & DIETING HISTORY

Please estimate as closely as possible for all that applies.

1. Approximate age when you first became overweight: _________ years old.
2. Approximate age when you first seriously dieted: _________ years old.
3. Please try to estimate your weight every five years after the age of 15

AGE	APPROXIMATE WEIGHT
Age 15	lbs
Age 20	lbs
Age 25	lbs
Age 30	lbs
Age 35	lbs
Age 40	lbs
Age 45	lbs
Age 50	lbs
Age 55	lbs
Age 60	lbs

4. How long have you been at your current weight? _____________Years _____________Months
5. Most recent weight loss attempt (successful or unsuccessful) was doing________________________ ____Date of this attempt: ________________
6. Your current diet and exercise regimen is:

____

List any **MEDICALLY SUPERVISED** Weight Loss attempts (list only those that were supervised by a physician, nurse practitioner, or physician's assistant):

MEDICALLY SUPERVISED DIET #1	**Supervising Provider** **Name:** **City:** **State:**	**Dates** Month / year to Month / year	**Length of Program** (months)	**Weight Lost**	**Weight Re-gained**
Prescription weight loss drugs used during this diet:	**Exactly what diet did you follow during *this time*?** How often did you see the Medical practitioner *during this diet*?				

MEDICALLY SUPERVISED DIET #2	**Supervising Provider** **Name:** **City:** **State:**	**Dates** Month / year to Month / year	**Length of Program** (months)	**Weight Lost**	**Weight Re-gained**
Prescription weight loss drugs used during this diet:	**Exactly what diet did you follow during *this time*?** How often did you see the Medical practitioner *during this diet*?				

MEDICALLY SUPERVISED DIET #3	**Supervising Provider** **Name:** **City:** **State:**	**Dates** Month / year to Month / year	**Length of Program** (months)	**Weight Lost**	**Weight Re-gained**
Prescription weight loss drugs used during this diet:	**Exactly what diet did you follow during *this time*?** How often did you see the Medical practitioner *during this diet*?				

Medication Consideration (Please check all that apply):

- ☐ I have tried prescription weight loss medications in the past and did not tolerate them or was unsuccessful on them.
- ☐ I have tried over-the-counter weight loss medications in the past and did not tolerate them or was unsuccessful on them.
- ☐ Because of other medical conditions I have, my primary care physician or practitioner does not believe I am a good candidate for prescription weight loss medications at this time.
- ☐ I am not interested in taking presciption or over-the-counter weight loss medication because of possible side-effects.

WEIGHT RELATED ILLNESSES

ALL PATIENTS: PLEASE FILL OUT THE FOLLOWING SECTIONS

1. High Blood Pressure Yes □ No □	□ On dietary restrictions for high blood pressure Explain:____________________ ____________________
Comments (For Office Use Only):	
2. Cardio / Vascular Disease Yes □ No □	If Yes please explain or check all that are applicable: □ Congestive Heart Failure □ Angina (exertional chest pain) □ Peripheral Vascular Disease / Stroke □ Coronary Artery Disease □ M.I. (myocardial infarction, heart attack) □ CABG (coronary artery bypass graft surgery) □ Other:
Comments (For Office Use Only):	
3. Frequent leg Swelling (Edema) Yes □ No □	If "Yes" how often do you have symptoms? ____________________ How do you treat your edema (elevation, medications, stocking)? ____________________
Comments (For Office Use Only):	
4. High Cholesterol High Triglycerides Yes □ No □	□ If "Yes" but not currently on medication to lower cholesterol or triglycerides, please explain how controlled: ____________________
Comments (For Office Use Only):	
5. Type 2 Diabetes Yes □ No □	□ Gestational (during pregnancy)
Comments (For Office Use Only):	
6. Gout Yes □ No □	□ If "Yes", please explain: ____________________
Comments (For Office Use Only):	

<table>
<tr><td>7. Sleep Apnea Syndrome
Yes □ No □

For office use only:

Positive s/s of Sleep Apnea
Yes □ No □</td><td>□ I have had a sleep study test
□ I use a CPAP / BIPAP
□ I use oxygen at night

SLEEP APNEA SCREENING: For Office Use only
0= would never dose, 1= slight chance of dozing, 2= moderate chance of dozing, 3= high chance of dozing
Situation — Chance of dozing
Setting and reading __0 __1__ 2__ 3
Watching TV __0 __1__ 2__ 3
Sitting, inactive in a public place (e.g., a theater or a meeting) __0 __1__ 2__ 3
As a passenger in a car for an hour without a break __0 __1__ 2__ 3
Lying down to rest in the afternoon when circumstances permit __0 __1__ 2__ 3
Sitting and talking to someone __0 __1__ 2__ 3
Sitting quietly after a lunch without alcohol __0 __1__ 2__ 3
In a car, while stopped for a few minutes in traffic __0 __1__ 2__ 3</td></tr>
<tr><td colspan="2">Comments (For Office Use Only):</td></tr>
<tr><td>8. Pulmonary Hypertension
Yes □ No □</td><td>Please Check all Symptoms that you have:
□ Tiredness / Fatigue
□ Shortness of Breath
□ Dizziness
□ Fainting</td></tr>
<tr><td colspan="2">Comments (For Office Use Only):</td></tr>
<tr><td>9. Asthma
Yes □ No □</td><td>If “Yes”, please explain how you treat it: ______________________________</td></tr>
<tr><td colspan="2">Comments (For Office Use Only):</td></tr>
<tr><td>10 Shortness of breath
Yes □ No □</td><td>□ Short of breath with exertion only
□ Short of breath at rest and with exertion
□ Short of breath at rest only
□ Low Saturation at rest or require oxygen</td></tr>
<tr><td colspan="2">Comments (For Office Use Only):</td></tr>
<tr><td>11. Frequent Heartburn (GERD)
Yes □ No □

H. Pylori?
Yes □ No □</td><td>If “Yes” how often do you have symptoms? ______________________________

What causes your symptoms? ______________________________
____

Present or History of Gallstones: Yes □ No □</td></tr>
<tr><td colspan="2">Comments (For Office Use Only):</td></tr>
</table>

12. Liver Disease Yes □ No □	If "Yes", please explain: ______________________________
Comments (For Office Use Only):	
13. Back pain / strain/ sciatica Yes □ No □	If "Yes", how often: ____________________ If "Yes", how do you treat it: ____________________
Comments (For Office Use Only):	
14. Joint Pain Yes □ No □	I have joint pain in my: □ Hips □ Knees □ Ankles □ Feet □Other: __________ If "Yes", how often: ____________________ If "Yes", how do you treat it: ____________________ Do you ever use assistive devices to walk or use a wheelchair? Yes □ No □ If "Yes" please explain*:* ______________________________
Comments (For Office Use Only):	
15. Fibromyalgia Yes □ No □	If "Yes", how is it treated: ______________________________
Comments (For Office Use Only):	
16. Polycystic Ovarian Syndrome *(Women Only)* Yes □ No □	If "Yes", did you receive treatment for this? Yes □ No □ If so, what was the treatment?______________________________ **Any other menstrual irregularities**? Yes □ No □ If so, please explain?______________________________
Comments (For Office Use Only):	
17. Depression Yes □ No □	Any other type of Mental Health Diagnosis? Yes □ No □ Any type of drug addiction? Yes □ No □ If so, please explain?______________________________
Comments (For Office Use Only):	

18. Urinary Stress Incontinence Yes □ No □	If yes, how often? ______________________________ If yes, do you ever have to wear a pad to for control? Yes □ No □
Comments (For Office Use Only):	
19. Obesity Related Skin Problems Yes □ No □	□ Rash under breasts □ Rash under arms □ Rash under abdominal folds of skin □ Rash in groin area □ Other:______________________________
Comments (For Office Use Only):	
20. Tumor (any) Yes □ No □	If so, please explain: ______________________________
Comments (For Office Use Only):	
21. Hernia Yes □ No □	If so, please explain type and treatment: ______________________________
Comments (For Office Use Only):	

PAST MEDICAL HISTORY

Other Medical Problems (not already mentioned above)	Date Diagnosed	Treating physician/practitioner
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST SURGICAL HISTORY

Surgeries and Procedures	Date	Doctor or Surgeon
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

MEDICATIONS

Please list all medications you are currently taking *including* over-the-counter & herbal remedies

Medication Name	Dosage	How often taken	Reason I take this medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

ALLERGIES

□ I have no known drug allergies
□ I have allergies to the following **MEDICATIONS**:

- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________

□ I have an allergy to latex
□ I have an allergy to surgical tape
□ I have "hay fever" type allergies to the environment
□ I have the following **FOOD** allergies:

- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________
- ____________________________Type of reaction:___________________________

SOCIAL HISTORY

Occupation				□ Retired
Disabled Yes □ No □	If "Yes" please explain ______________________________ ______________________________			Date of Disability:
Marital status	□ Single □ Married □ Divorced □ Widowed □ Significant Other			
Children	Age	Daughter or son	Age	Daughter or son

Yes □ No □ Is your spouse/significant other aware and supportive of your decision to consider weight loss surgery?

Support System Please describe your social support system (spouse, friends, family, people you know who have had weight loss surgery) you may rely on after surgery:____

____

1. Do you use tobacco? Yes □ No □ If Yes, what type: □ Cigarettes □ Cigars □ Chewing tobacco □ Pipe	**If you DO use tobacco -** How much per day do you use? ____________ For how many years _______ ______________ Are you willing to quit? Yes □ No □ **If you DID use tobacco**- When did you quit? _________________ How many packs/cans per day did you use? ____________ For how many years did you use it? ______________
For office use only: Patient carries a _________-pack-year history of tobacco use.	
2. Do you drink alcohol? Yes □ No □	How often? ____________________________________ How much? ____________________________________ Do you drink alcohol on most every day? Yes □ No □ How much in the average week? _______________________
3. Do you **have** or have you **had** dependencies to drugs, alcohol, etc? Yes □ No □	If Yes, please give details:
4. Have you used illicit drugs? Yes □ No □ Have you **injected** illicit drugs? Yes □ No □ How recently have you used illicit drugs?	If Yes, please give details:

FAMILY HISTORY

Family Member	Current Age	Age Deceased	Cause of Death	Family history of disease / Illness
Mother				Obese? Yes □ No □ Other Medical Problems:
Father				Obese? Yes □ No □ Other Medical Problems:
Maternal Grandmother				Obese? Yes □ No □ Other Medical Problems:
Maternal Grandfather				Obese? Yes □ No □ Other Medical Problems:
Paternal Grandmother				Obese? Yes □ No □ Other Medical Problems:
Paternal Grandfather				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Sibling Bro Sis				Obese? Yes □ No □ Other Medical Problems:
Child Son Dtr				Obese? Yes □ No □ Other Medical Problems:
Child Son Dtr				Obese? Yes □ No □ Other Medical Problems:
Child Son Dtr				Obese? Yes □ No □ Other Medical Problems:
Child Son Dtr				Obese? Yes □ No □ Other Medical Problems:
Child Son Dtr				Obese? Yes □ No □ Other Medical Problems:

REVIEW OF SYSTEMS

(Check symptoms which you have **PRESENTLY**. For positive responses, please give details.)

GENERAL/CONSTITIONAL

	Weakness		Fever
	Fatigue		Night sweats

Details:

SKIN/HAIR/NAILS

	Rash		Lumps
	Sores		Itching
	Dry skin		Changes in hair
	Skin color changes/changes in pigmentation		Nail changes

Details:

HEAD, EYES, EARS, NOSE, THROAT and NECK:

	HEAD		**EARS**
	Headaches		Loss of hearing
	Head injury		Ringing in the ears
	Dizziness		Ear discharge
	Lightheadedness		Earache
	EYES		Vertigo (Spinning sensation)
	Recent change in vision		Frequent ear infections
	Eye pain		Hearing aids
	Double vision		**MOUTH / THROAT**
	Blind spots		Dentures
	Cataracts		Sore teeth / toothache
	Contacts / Glasses		Sore gums/ bleeding gums
	Glaucoma		Sore tongue
	NOSE		Frequent sore throats
	Nasal stuffiness		Hoarseness
	Nasal discharge / itching		**NECK**
	Breathing obstruction		Swollen glands
	Nose bleeds		Neck stiffness/ tenderness/ or pain
	Post nasal drainage		Goiter

Details:

BREASTS (For men and women both):

	Lumps		Pain or discomfort
	Nipple discharge		I do breast self-exams every ________________ months

Details:

RESPIRATORY:

	Short of breath		Oxygen use
	Frequent cough		**COPD**
	Bloody sputum		**Bronchitis or Chronic Bronchitis**
	Sputum (color, amount, time of day—give details below)		**Tuberculosis or Exposure to tuberculosis**
	Wheezing		**Emphysema**
	Inhaler use		**Asthma**
Details:			

CARDIOVASCULAR:

	Heart murmur		**Bradycardia** (abnormally slow heart rate)
	Cyanosis		**Tachycardia** (abnormally fast heart rate)
	Palpitations		**Angina** (chest pain or discomfort)
	Abnormal EKG		**Phlebitis** (inflammation of the veins)
	Pacemaker		**Claudication** (pain in legs with activity)
	Dyspnea (short of breath with exertion)		**Chronic Venous Insufficiency** (ulcers on lower legs)
	Syncope (blacking-out)		**DVT / PE** (blood clots in legs or lungs)
	Edema (swelling of legs / feet)		**Varicose veins**
	Arrhythmia (abnormal heart rhythm/beat)		**Orthopnea** (short of breath when lying flat)
Details:			

GASTROINTESTINAL:

	Nausea (persistent)		Hemorrhoids		**Duodenal or gastric ulcer**
	Vomiting (frequent)		Pain on bowel movement		**Pancreatitis**
	Vomiting blood or dark material		Abdominal pain		**Liver disease**
	Diarrhea (frequent)		Jaundice		**Hepatitis**
	Constipation (frequent)		Difficulty or pain with swallowing		**Cirrhosis**
	Blood in stools		Frequent hoarseness		**Irritable bowel syndrome**
	Heartburn		**Barrett's esophagus**		**Ulcerative colitis**
	Recent changes in bowel habits		**Hiatal hernia**		**Crohn's disease**
Details:					

URINARY:

	Frequent urination		Frequent or recent urinary tract infections
	Blood in urine		Kidney insufficiency, compromise in kidney function
	Difficulty or pain passing urine		Getting up at night to urinate (nocturia) How many times per night? ________
	Kidney stones		**Chronic Kidney Disease**
	kidney infection		**End-stage Renal Disease**
Details:			

WOMEN—OB/GYN

Number of pregnancies:	Number of live births:	Miscarriages/abortions:
Age at first period:	Date of last period:	Date of last Pap:
Obstetric complications (Please give details):		
Infertility Problems (please give details):		
Are you planning additional pregnancies?		Yes □ No □
Are you willing to use birth control during your weight loss (at least 2 years)?		Yes □ No □
What types of birth control do you or are you willing to use?		

	Irregular periods		Sexually transmitted diseases
	Abnormally heavy periods		Pain with intercourse (dysparunia)
	Vaginal discharge		Abnormal pap smear
	Vaginal bleeding after menopause		Sores in the perineal area (vaginal/rectal area)
Details:			

MEN—GENITOURINARY:

	Penile discharge		Sexually transmitted diseases
	Pain on urination		Infection of the penis, testicles, prostate, or groin
	Pain or masses in the genitals		**Enlarged prostate**
	Difficulty passing urine		**Impotence**
	Pain with intercourse		**Inguinal hernias**
Details:			

MUSCULOSKELETAL:

	Swelling of joints		**Connective tissue disorder**
	Redness of skin over joints		**Lupus**
	Fluid in joints		**Scleroderma**
	Muscular weakness		**Gout**
	Herniated or slipped disc		**Osteoarthritis**
	Frequent muscle cramps		
Details:			

NEUROLOGICAL:

	Dizziness		Black-out spells		Weakness of any muscles
	Fainting spells		Shakiness		Painful burning of the feet (neuropathy)
	Numbness		Seizures		Loss of consciousness
	Tremor		Twitching of muscles		Abnormal sensation or tingling
	Sciatica		Drooping of the face		**Stroke or TIA**
Details:					

ENDOCRINE (GLANDULAR):

	Frequent heavy sweating		**Thyroid nodule or mass**
	Hot flashes		**Thyroid cancer**
	Goiter		**Low thyroid (hypo-thyroid)**
	Excessive Thirst		**High thyroid (hyper-thyroid)**
	Excessive urination		**Hyperparathyroidism**
	Significantly and frequently hotter than everyone else		**Polycystic ovaries**
	Significantly and frequently colder than everyone else		**Adrenal gland tumor**
	Change in glove or shoe size		**Fatigue**
Details:			

PSYCHOLOGICAL:

	Nervousness		Hospitalized for emotional problems
	Psychological counseling		**Anxiety**
	Psychiatric treatment		**Depression**
	Thoughts of suicide ĩ previous ĩ recent		**Bipolar Affective Disorder**
	Suicide attempts? How many? ________		**Schizophrenia**
Details:			

ANESTHESIA AND BLOOD DISEASES:

	Bleeding from gums		Blood transfusion
	Easy and frequent bruising		Blood transfusion reaction
	Excessive bleeding after surgery		**Iron Deficiency**
	Had or have trouble with anesthesia		**Vitamin B12 deficiency**
	Any family member ever had trouble with anesthesia?		**Anemia (low red blood cell count)**
Details:			

DIET AND EXERCISE HISTORY

DIETS ***(Please list the diets and diet programs you have tried. Provide as many details as possible):***

Medications/Pills		Dates	MD Supervised?	Wt Lost	Wt Re-gained
Accutrim	Yes □ No □		Yes □ No □		
Dexatrim	Yes □ No □		Yes □ No □		
Diurex	Yes □ No □		Yes □ No □		
Fen/Phen /Redux	Yes □ No □		Yes □ No □		
Meridia	Yes □ No □		Yes □ No □		
Xenical	Yes □ No □		Yes □ No □		
Phentermine:	Yes □ No □		Yes □ No □		
Alli	Yes □ No □		Yes □ No □		
Hoodia	Yes □ No □		Yes □ No □		
Relacore	Yes □ No □		Yes □ No □		
Other:	Yes □ No □		Yes □ No □		
Alternative Methods		**Dates**	**MD Supervised?**	**Wt Lost**	**Wt Re-gained**
Acupuncture	Yes □ No □		Yes □ No □		
Hypnosis	Yes □ No □		Yes □ No □		
Psychotherapy	Yes □ No □		Yes □ No □		
Other:	Yes □ No □		Yes □ No □		
Other Diets/ Programs		**Dates**	**MD Supervised?**	**Wt Lost**	**Wt Re-gained**
Jenny Craig	Yes ☐ No ☐		Yes ☐ No ☐		
Lindora	Yes ☐ No ☐		Yes ☐ No ☐		
Nutri-Systems	Yes ☐ No ☐		Yes ☐ No ☐		
Opti/Medi Fast	Yes ☐ No ☐		Yes ☐ No ☐		
Overeaters Anonymous	Yes ☐ No ☐		Yes ☐ No ☐		
Slim for Life	Yes ☐ No ☐		Yes ☐ No ☐		
T.O.P.S.	Yes ☐ No ☐		Yes ☐ No ☐		
Weight Watchers	Yes ☐ No ☐		Yes ☐ No ☐		
L.A. Weight Loss	Yes ☐ No ☐		Yes ☐ No ☐		
Metabolic Research Center	Yes ☐ No ☐		Yes ☐ No ☐		
Liquid Protein	Yes ☐ No ☐		Yes ☐ No ☐		
Metracal	Yes ☐ No ☐		Yes ☐ No ☐		
Sego	Yes ☐ No ☐		Yes ☐ No ☐		
Slim Fast	Yes ☐ No ☐		Yes ☐ No ☐		
Atkins Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Dr Phil's Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Grapefruit Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Herbalife	Yes ☐ No ☐		Yes ☐ No ☐		
Herbal Diet	Yes ☐ No ☐		Yes ☐ No ☐		
High Protein Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Hollywood Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Low Calorie Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Richard Simmons	Yes ☐ No ☐		Yes ☐ No ☐		
Scarsdale	Yes ☐ No ☐		Yes ☐ No ☐		
South Beach	Yes ☐ No ☐		Yes ☐ No ☐		
Cabbage Soup Diet	Yes ☐ No ☐		Yes ☐ No ☐		
Other:	Yes ☐ No ☐		Yes ☐ No ☐		
Other:	Yes ☐ No ☐		Yes ☐ No ☐		

Exercise Programs	
Yes ☐ No ☐ Have you ever formally exercised as a part of a medically supervised diet?	
Yes ☐ No ☐ Did you exercise in conjunction with any of the above diets?	
Give some comments or details about your exercise experience:	
Fitness Centers	Yes ☐ No ☐ Have you belonged to fitness centers in the past?
	Yes ☐ No ☐ Have you gone regularly to a fitness center to lose weight at any time in your life?
	Yes ☐ No ☐ Have you worked with a personal exercise trainer?
Give some comments or details about your fitness center experience:	
Exercise Videos	Give some comments or details about your exercise video experience:
Home Exercise Equipment purchased:	Give some comments or details about your home exercise experience:
Types of exercise □ Aerobics □ Bicycling □ Free Weights □ Nautilus □ Jogging □ Swimming □ Walking □ Spinning □ Yoga	**IMPORTANT: Please give details and a summary of your exercise attempts and experience:**

Eating Disorders		
Anorexia	Yes □ No □	Details:
Bulimia	Yes □ No □	Details:
Laxatives used for weight loss	Yes □ No □	Details:
Diuretics used for weight loss	Yes □ No □	Details:
Compulsive Overeating	Yes □ No □	Details:
In-Patient treatment	Yes □ No □	Details:
Out-Patient treatment	Yes □ No □	Details:

PLEASE LIST ALL PHYSICIANS WHOSE CARE YOU ARE OR HAVE BEEN UNDER FOR THE **PAST 5 YEARS**:

Make sure to give **complete addresses** for these physicians. We will be sending requests for your medical records of weight-related appointments and treatments. Failure to provide complete addresses could result in this form being returned to you for completion which could slow down your interview process. For insurance reasons, it is **imperative** that we have the past 5 years of your medical history. If you have not been a patient of your primary care doctor/practitioner for **at least** 5 years please give us the information of the other primary care doctors/practitioners whose care you have been under.

Primary Care Doctor/Practitioner	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Primary Care Doctor/Practitioner	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Primary Care Doctor/Practitioner	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Internist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
OB/GYN	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Orthopedist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Cardiologist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Pulmonologist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Gastroenterologist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Psychiatrist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Psychologist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Counselor/Therapist	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Other:	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:
Other:	Name:	Phone:	Fax:
	Street:	City:	State/Zip:
	I have been/was under the care of this practitioner from:		to:

USE THIS FORM TO CHRONOLOGICALLY SUMMARIZE YOUR WEIGHT LOSS ATTEMPTS

This form goes to your Insurance Company - It is EXTREMELY important to complete as thoroughly as possible.

Name: ______________________________

YEAR	TYPES OF DIETS	MD SUPERVISED?	# LOST	LENGTH OF PROGRAM	# GAIN	EXERCISE	COUNSELING?	RECORDS AVAILABLE?