



Diets **Supervised Diets** Weight Loss Meds Behavioral Changes

- Diet Center
- HMR
- Jenny Craig
- LA Weight Loss
- Nutri-Systems
- Opti-Fast / Medi-Fast
- Overeaters Anonymous
- Physicians Weight Loss Center
- TOPS
- Weight Watchers

d Diets Supervised Diets **Weight Loss Meds** Behavioral Changes

- Acutrim
- Amphetamines
- Anorex
- Byetta
- Dexatrim
- Didrex
- Ionamin / Adipex
- Fastin
- Fen - Phen  # of months
- Mazanor
- Meridia
- Obalan
- Phendiet
- Phentrol
- Phenteramine
- Plegine
- Pondimin
- Prozac
- Redux  # of months
- Sanorex
- Tenuate
- Tepanole
- Wechless
- Wellbutrin
- Xenical

ed Diets Supervised Diets Weight Loss Meds **Behavioral Changes**

**Exercise:**

- Walking or Running
- Stationary cycle or treadmill
- Swimming
- Weight Training
- Team sports

**Therapies:**

- Hospitalization
- Hypnosis
- Physical Therapy
- Psychological Therapy
- Residential Programs

**Please list Medications you are currently taking, Allergy information, and Vitamin information:**

Weight Hx	Allergies / Medications	Medical Hx	Surgical Hx	Disability	Family Hx	Social Hx
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Medications

Medication	Dose	Dose unit	Frequency	Administered

  

Allergies

Date	Type	Allergen	Severity	Reaction	Source	Comment

  

No known drug allergies

No known allergies to latex

No known allergies to iodine

No known allergies to IV contrast

No known allergies to adhesives

**Vitamins**

Multiple Vitamin

Calcium

Vitamin B-12

Iron

Vitamin D

Vitamin A, D, E combo

Calcium with vitamin D

**Additional Info**

**Please enter your Medical History:**

Weight Hx	Allergies / Medications	Medical Hx	Surgical Hx	Disability	Family Hx	Social Hx
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<input type="checkbox"/> Angina	<input type="checkbox"/> Fatty liver (nonalcoholic)	<input type="checkbox"/> Pseudotumor cerebri
<input type="checkbox"/> Allergic rhinitis	<input type="checkbox"/> Fibrocystic disease	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> GERD	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Sleeping Disorder
<input type="checkbox"/> CAD (no CABG)	<input type="checkbox"/> Glucose intolerance	<input type="checkbox"/> Stress Urinary Incontinence
<input type="checkbox"/> CAD (with CABG)	<input type="checkbox"/> Gout	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Chest pain with exertion	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Venous insufficiency
<input type="checkbox"/> Cholelithiasis	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Hypertriglyceridemia	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> CVA	<input type="checkbox"/> Infertility	
<input type="checkbox"/> Deep Venous Thrombosis	<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Degenerative Disk Disease	<input type="checkbox"/> Intermittent Claudication	
<input type="checkbox"/> Depression	<input type="checkbox"/> Intertriginous Dermatitis	
<input type="checkbox"/> Diabetes Type I (controlled)	<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Diabetes Type I (uncontrolled)	<input type="checkbox"/> Joint Pain	
<input type="checkbox"/> Diabetes Type II (controlled)	<input type="checkbox"/> Menstrual Irregularity	
<input type="checkbox"/> Diabetes Type II (uncontrolled)	<input type="checkbox"/> Metabolic syndrome	
<input type="checkbox"/> Dysfunctional Uterine Bleeding	<input type="checkbox"/> Migraine headaches	
<input type="checkbox"/> Dysmenorrhea	<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Dyspnea with Exertion	<input type="checkbox"/> Peripheral Edema	
<input type="checkbox"/> Elevated liver enzymes	<input type="checkbox"/> Peripheral vascular disease	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Peptic Ulcer	
<input type="checkbox"/> Fatty liver (alcoholic)	<input type="checkbox"/> Polycystic ovarian syndrome	

**Osteoarthritis**

<input type="checkbox"/> Ankles / Foot	<input type="checkbox"/> Knees
<input type="checkbox"/> Elbows	<input type="checkbox"/> Neck / back
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Hips	<input type="checkbox"/> Wrist

**Pain**

<input type="checkbox"/> Ankles / Foot	<input type="checkbox"/> Knees
<input type="checkbox"/> Elbows	<input type="checkbox"/> Neck / back
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Hips	<input type="checkbox"/> Wrist

**Other Medical History**

**Please enter your Surgical History:**

Weight Hx	Allergies / Medications	Medical Hx	<b>Surgical Hx</b>	Disability	Family Hx	Social Hx
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**Previous Non-Bariatric Surgeries (BOLD)**

<input checked="" type="checkbox"/> Anti-reflux procedure	<input type="checkbox"/> Breast cancer, radiation	<input type="checkbox"/> Breast cancer, biopsy
<input type="checkbox"/> Breast cancer, mastectomy	<input type="checkbox"/> Bowel resection	<input type="checkbox"/> CABG
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hip replacement	<input type="checkbox"/> Hysterectomy (+/- oophorectomy)
<input type="checkbox"/> Knee replacement	<input type="checkbox"/> Laminectomy	<input type="checkbox"/> Nissen fundoplication
<input type="checkbox"/> Peripheral vascular procedure	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Vagotomy
<input type="checkbox"/> Vasectomy		

**Previous Bariatric Surgeries (BOLD)**

Year	Name	Surgeon ID

**Cholecystectomies**

Open

Laparoscopic

**Hysterectomies**

Open hysterectomy with oophorectomy

Open hysterectomy w/o oophorectomy

Lap hysterectomy with oophorectomy

Lap hysterectomy w/o oophorectomy

Vaginal hysterectomy with oophorectomy

Vaginal hysterectomy w/o oophorectomy

**Other previous surgeries**

<input type="checkbox"/> Appendectomy (open)	<input type="checkbox"/> Inguinal hernia repair (open)	<input type="checkbox"/> Cesarean section
<input type="checkbox"/> Appendectomy (laparoscopic)	<input type="checkbox"/> Inguinal hernia repair (laparoscopic)	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Incisional hernia repair (open)	<input type="checkbox"/> Umbilical hernia repair (open)	<input type="checkbox"/> Wisdom teeth extraction
<input type="checkbox"/> Incisional hernia repair (laparoscopic)	<input type="checkbox"/> Umbilical hernia repair (laparoscopic)	<input type="checkbox"/> Arthroscopy
		<input type="checkbox"/> Breast lumpectomy

**Other Surgeries**

**Issues with Anesthesia**

No anesthesia related problems

Description

**Please enter Disability Information:**

Weight Hx	Allergies / Medications	Medical Hx	Surgical Hx	<b>Disability</b>	Family Hx	Social Hx
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**Check here if you are disabled**      Year of disability       Cause

Motor vehicle crash       Work related injury  
 Disability due to illness       Other

**Check here if you require assisted devices**      Type

Cane       Walker  
 Crutches       Braces

**Check here if you require a wheelchair or motorized scooter**      How long in a wheelchair?  (years)

**Please enter Family History:**

Weight Hx	Allergies / Medications	Medical Hx	Surgical Hx	Disability	<b>Family Hx</b>	Social Hx
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**Family History**

Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Hypertension	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Cardiovascular	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Renal Failure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Arthritis/Joint Replacement	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather

Other

**Please enter Social History:**

Weight Hx	Allergies / Medications	Medical Hx	Surgical Hx	Disability	Family Hx	<b>Social Hx</b>
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**Smoking**

Do you currently smoke  Yes  No

How many packs per day  <1 PPD  1 to 2 PPD  2 to 3 PPD  3 to 4 PPD  >4 PPD

Smoke in the past  Yes  No Date patient quit:  How many years ago the patient quit smoking:

**Alcohol**

Do you drink alcohol  Yes  No

How many times per week

How many drinks each time

**Street Drugs**

Do you use illicit drugs  Yes  No

How often  Less than once a day  Once per day  
 Several times a day  Once per week  
 Several per week

Type  Cocaine  Marijuana  
 Ecstasy  Pain medications  
 Heroin  Other prescription medications

**Additional Information**