MEDICAL/SURGICAL HISTORY FORM

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Surgical Patients Only:

Please check the weight loss procedure that you are interested in:

- ☐ Gastric Bypass
- ☐ Lap Band
- ☐ Undecided
- ☐ Revision of Previous Surgery

Physician use only

HT _____

WT _____

BMI _____

Medical History **(please circle yes or no to the following questions)**

Has a Doctor or Health Professional ever told you that you have or treated you for any of the following?

Nervous System:

Stroke, mini stroke, or one-sided weakness?	NO	YES
Chronic headaches/migraines?	NO	YES
Seizures?	NO	YES
Numbness or tingling in neck, arms, or hands?	NO	YES

Heart and Circulation:

High blood pressure?	NO	YES
High cholesterol?	NO	YES
Congestive heart failure?	NO	YES
Heart attack?	NO	YES
Heart valve abnormalities?	NO	YES
Abnormal heart rhythms?	NO	YES
Do you ever experience chest pain or palpitations?	NO	YES
Symptoms with exercise?	NO	YES

If yes, explain: _____

Heart stress test?	NO	YES
Cardiac catheterization or angioplasty?	NO	YES
Pacemaker or implantable defibrillator?	NO	YES

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Physician use only

Lungs and Breathing:

Sleep apnea?	NO	YES
CPAP or BIPAP machine?	NO	YES
Have you ever had a sleep study?	NO	YES
Asthma?	NO	YES
Emphysema or COPD?	NO	YES
Pulmonary embolus?	NO	YES

How many blocks can you walk without becoming short of breath?
(please circle one of the choices listed below)

Less than 1/2 block 1/2 block 1 block 1-2 blocks more than 2 blocks

Liver, Gallbladder, Stomach, Intestine

GERD/Acid Reflux?	NO	YES
Heartburn?	NO	YES
If yes, how many times per week?	____ times/week	
Difficulty swallowing food or liquid?	NO	YES
Gallstones?	NO	YES
Pancreatitis?	NO	YES
Cirrhosis?	NO	YES
Stomach/duodenal ulcers?	NO	YES
Hiatal hernia?	NO	YES
Hepatitis (A, B or C)?	NO	YES
Crohns/Ulcerative Colitis?	NO	YES
Irritable Bowel Syndrome?	NO	YES
Chronic constipation?	NO	YES
History of GI cancer?	NO	YES
Have you ever had a colonoscopy, barium enema, or upper endoscopy?	NO	YES

If yes, include the date and reason why:

_____

_____

_____

_____

Job: CL3979
CWM-114
2nd Proof: 11/30/07
Back pt. 1
Ink: Black
Paper: 20# White

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Physician use only

Blood and Clotting:

Are you willing to accept a blood transfusion?	NO	YES
Anemia?	NO	YES
Sickle cell disease?	NO	YES
Clotting or platelet disorder?	NO	YES
Deep Venous Thrombosis (DVT)?	NO	YES
Have you ever been on Coumadin?	NO	YES

Are you on any of the following?:

Aspirin Plavix NSAIDS (Ibuprofen, Advil, Motrin, Naprosyn)

Endocrine:

Diabetes?	NO	YES
Thyroid disease?	NO	YES
Polycystic ovarian syndrome?	NO	YES
Cushings Disease?	NO	YES
Excessive thirst, urination, or hunger?	NO	YES
Visual changes (wavy lines, spots)?	NO	YES
Changes in body temperature (very cold or hot)?	NO	YES

Miscellaneous:

Depression?	NO	YES
Schizophrenia?	NO	YES
Other psychiatric disorder?	NO	YES
Joint pain (hip, knee, ankle, lower back)?	NO	YES

If yes, circle the areas that are affected

Lower back hip knee ankle

Urinary stress incontinence?	NO	YES

If yes, how many pads do you use per day? ____ pads/day

Kidney stones and/or other kidney disease?	NO	YES

Carolinas Weight Management & Wellness Center

Medical/Surgical History Form

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Job: CL3979
CWM-114
2nd Proof: 11/30/07
face pt. 2
Ink: Black
Paper: 20# White

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Miscellaneous continued:

HIV? NO YES

Autoimmune disease (rheumatoid arthritis, lupus, etc)? NO YES

If yes, please explain:

_____

_____

_____

_____

Pregnancy History:

How many times have you been pregnant? _____

How many times have you delivered? _____

Have you ever had a c-section? NO YES

(If yes, how many)? _____

Complications following delivery or c-section? NO YES

Problems during pregnancy (increased BP or blood sugar)? NO YES

Have you ever had a tubal ligation? NO YES

Have you ever had problems becoming pregnant? NO YES

If yes, please explain:

_____

_____

_____

Surgical History:

Have you ever had prior surgery? NO YES

Have you ever had weight loss surgery? NO YES

If yes, list all surgeries that you have had and the year in which they occurred:

_____

_____

_____

_____

_____

Physician use only

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Surgical History continued:

Have you ever experienced any of the following after surgery?

Blood clot(s)?	NO	YES
Abnormal bleeding?	NO	YES
Problems with anesthesia?	NO	YES

If yes please explain:

_____

_____

Difficulty healing?	NO	YES

If yes please explain:

_____

_____

Drug Allergies?	NO	YES

If yes, describe the reaction you had:

_____

_____

Physician use only

Social History:

Current smoker?	NO	YES
If yes, how much do you smoke (pack(s)/day): _____ pack(s)/day		
How many years have you smoked: _____ years		
Past smoker?	NO	YES
If yes, indicate the number of months since you quit: _____ months		
Drink alcoholic beverages?	NO	YES
If yes, indicate the number of drinks/week: ____ drinks/week		
Current IV drug use?	NO	YES
Past IV drug use?	NO	YES
Do you live alone?	NO	YES
Do you use a wheelchair or walker?	NO	YES

Occupation: _____

Carolinas Weight Management
& Wellness Center

Medical/Surgical History Form

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Job: CL3979
CWM-114
2nd Proof: 11/30/07
face pt. 3
Ink: Black
Paper: 20# White

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Family History: (parents and siblings):

Check here if your family history is unknown ☐

Obesity	NO	YES
High Cholesterol	NO	YES
Bleeding	NO	YES
Diabetes	NO	YES
High blood pressure	NO	YES
Heart disease	NO	YES
Heart Attack	NO	YES
DVT or thrombosis	NO	YES
Cancer	NO	YES
Anesthesia difficulty	NO	YES
Sleep apnea	NO	YES
Asthma	NO	YES

Physician use only

Current medications:

Please include all prescriptions and over the counter medications, herbs and vitamins. (You may bring a separate list)

Medication	Dose	Frequency

Carolinas Weight Management & Wellness Center

Medical/Surgical History Form

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Job: CL3979
CWM-114
2nd Proof: 11/30/07
back pt. 3
Ink: Black
Paper: 20# White

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Please check all previous weight loss program or medications you have tried:

Program	Date	Weight (lost or gained)	Length of participation
Weight Watchers			
Overeaters Anonymous			
Liquid diets (optifast)			
Diet pills (phen-fen, redux)			
Diet pills (meridia, xenical)			
Nutrisystem			
Jenny Craig			
OTC diet pills			
Nutritionist/dietitian			
Surgery			
Other			

Physician use only

Carolinas Weight Management & Wellness Center

Medical/Surgical History Form

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Job: CL3979
CWM-114
2nd Proof: 11/30/07
face pt. 4
Ink: Black
Paper: 20# White

Name: _____ **DOB:** ____ /____ /_____ **Date:** ____ /____ /_____

Surgical Candidates Only:

PERSONAL STATEMENT

PLEASE TELL US IN YOUR OWN WORDS WHY YOU ARE PURSUING WEIGHT LOSS SURGERY – GIVE THREE DIFFERENT REASONS FOR ENTERING THE PROGRAM AND INCLUDE ANY PERSONAL GOALS. PLEASE USE ADDITIONAL PAPER IF NECESSARY.