



**Weight Loss Surgery Well-Being Assessment**

Name \_\_\_\_\_

**Weight History**

For Office use only

Actual body weight \_\_\_\_\_  
 Height \_\_\_\_\_  
 Ideal body weigh \_\_\_\_\_

Procedure \_\_\_\_\_  
 Weight in office \_\_\_\_\_  
 BMI \_\_\_\_\_  
 Vitals T: \_\_\_ P \_\_\_ R \_\_\_

What was your weight at: \_\_\_\_\_ Age \_\_\_\_\_

1. Birth \_\_\_\_\_
2. High School graduation \_\_\_\_\_
3. Marriage \_\_\_\_\_
4. Lowest weight in past 5 years \_\_\_\_\_
5. Highest weight in past 5 years \_\_\_\_\_

**Dietary History**

Approximate age when you first seriously started dieting \_\_\_\_\_

<b><u>Program</u></b>	<b><u>Dates</u></b>	<b><u>Duration</u></b>	<b><u>Dr. Supervision</u></b>	<b><u>Wt Loss</u></b>
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Jenny Craig

Nutri/Systems

Weight Watchers

Optifast

Fen Phen

Meridia

T.O.P.S.

O.A.

L.A. Weight Loss

Atkin's

*List any other physician supervised and documented weight loss attempts:*

*List all other diets and/or weight loss attempts including memberships to health and fitness clubs:*

*Do you currently exercise?*

## **Food Preferences**

*Indicate which foods would most likely make you go off a diet by ranking each selection  
From 1 (like very much) to 4 (don't care)*

Soda \_\_\_\_\_

High fat foods \_\_\_\_\_

High salt foods \_\_\_\_\_

Sugary foods \_\_\_\_\_

How many meals do you eat per day? \_\_\_\_\_

If you skip a meal, which one is it? \_\_\_\_\_

Do you feel like your portions are bigger than normal? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you snack between meals? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what time of the day? \_\_\_\_\_

How many times per week do you eat out? Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

How much soda pop do you drink? \_\_\_\_\_ Regular or diet?

Specifically, what are your favorite foods? (meat and potatoes, pastas, pizza, etc.)

## **Weight Related Illnesses**

*Have you ever had any of the following illnesses or symptoms?*

		Year diagnosed
1. Heart Disease	_____	_____
2. High Cholesterol	_____	_____
3. High blood pressure	_____	_____
4. Diabetes	_____	_____
5. Asthma	_____	_____
6. Shortness of breath	_____	_____
7. Sleep apnea	_____	_____
Have you ever had a sleep study? (Please circle) Yes or No		
If yes, do you have a pulmonologist?		
Do you use CPAP _____ pressure _____		
8. Obesity hyperventilation syndrome?	_____	_____
9. Coughing or choking at night?	_____	_____

10. Heartburn? \_\_\_\_\_
11. Acid reflux? \_\_\_\_\_
12. Leakage of urine with laughing, coughing, or sneezing? \_\_\_\_\_
13. Low back pain? \_\_\_\_\_
14. Pain in weightbearing joints? (Circle) Hips / Knees / Ankles / Feet
15. Weight related injuries or traumas? \_\_\_\_\_
16. Swelling in extremities (edema)? \_\_\_\_\_
17. Thyroid disease? \_\_\_\_\_
18. Have you ever had an Upper GI or endoscopy? \_\_\_\_\_
19. Pneumonia? \_\_\_\_\_

**Other medical problems not covered previously on this form:**

- 1.
- 2.
- 3.

**Surgical History**

*Please list all surgeries you have had, including the year:*

*If you have had previous weight loss surgery, you will need to obtain a copy of the operative report and bring it with you to this appointment or have it faxed to me at (402) 441-4764.*

## **Medications and Allergies**

Please list all medications and dosages you are currently using (include Herbals and OTC)

- |    |     |
|----|-----|
| 1. | 6.  |
| 2. | 7.  |
| 3. | 8.  |
| 4. | 9.  |
| 5. | 10. |

Allergies to medications and reactions:

Allergies to tape or latex?

## **Family History**

*Do you have a family history of:*

- |                                     |       |
|-------------------------------------|-------|
| Obesity                             | _____ |
| Diabetes                            | _____ |
| High blood pressure                 | _____ |
| Heart disease                       | _____ |
| High cholesterol                    | _____ |
| Lung disease                        | _____ |
| Kidney disease                      | _____ |
| Bleeding tendency or blood disorder | _____ |
| Breast cancer                       | _____ |
| Colon cancer                        | _____ |

## **Social History**

Type of work that you do: \_\_\_\_\_

Do you smoke: Y or N If so, how much? \_\_\_\_\_ Quit? \_\_\_\_\_ When? \_\_\_\_\_

Do you drink alcohol: Y or N If so, how much? \_\_\_\_\_

Ever being treated for addiction? (alcohol, prescription meds, drugs) \_\_\_\_\_

1. Have you had trouble sleeping? Yes \_\_\_\_ No \_\_\_\_

2. Do you feel like life is not worth living? Yes \_\_\_\_ No \_\_\_\_

3. Do you feel sad and “empty” all the time? Yes \_\_\_\_ No \_\_\_\_

4. Have you had any changes in appetite? Yes \_\_\_\_ No \_\_\_\_

5. Do you feel like you have lost interest in your usual activities? Yes \_\_\_\_ No \_\_\_\_

### **For Female Patients Only**

Number of pregnancies \_\_\_\_\_

Number of live births \_\_\_\_\_

Miscarriages/abortions \_\_\_\_\_

Age at first period \_\_\_\_\_

Date of last period \_\_\_\_\_

### **Physicians**

*Please list all the physicians whose care you are under and what town they are located in:*

Primary Care Physician:

Gynecologist:

Orthopedist:

Psychiatrist:

Psychologist:

*In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:*