Florida Surgical Weight Loss Centers

Patient History

Patient Name:_____ **DOB:**_____ **Age:**_____**Date Completed**:_____

Primary Care Physician: _____**Reason for Visit**:_____

Medical History

☐ Alcoholism	☐ Cancer	☐ Fibromyalgia	☐ MRSA/VRE
☐ Allergies	☐ Cardiac arrest	☐ Gallbladder disease	☐ Myocardial infarction
☐ Anemia	☐ Cardiac dysrhythmias	☐ GERD	☐ Obesity
☐ Angina	☐ Cardiac Valvular disease	☐ Hepatitis C	☐ Osteoarthritis
☐ Anxiety	☐ Cerebrovascular accident	☐ HIV/AIDS	☐ Osteoporosis
☐ Arthritis	☐ COPD	☐ Hypothyroidism	☐ Peptic ulcer disease
☐ Asthma	☐ Coronary artery disease	☐ Hyperlipidemia	☐ Psychosis
	Crohn's disease	☐ Hypertension	
☐ Atrial fibrillation	☐ Dementia	☐ Inflammatory bowel disease	☐ Pulmonary fibrosis
☐ Benign prostatic hypertrophy	☐ Depression	☐ Infertility / Menstrual problems	☐ Radiation
☐ Bleeding disorder	☐ Diabetes	☐ Liver disease	☐ Renal disease
☐ Blood clots	☐ DVT	☐ Low back pain	☐ Seizure disorder
☐ Blood transfusion	☐ Endocarditis	☐ Malignant hyperthermia	☐ Sleep apnea
☐ Other:_____	☐ Other:_____	☐ Migraine headaches	☐ Thyroid disease

Family History *List any known medical problems in your immediate family*

Father: ☐ Alive ☐ Deceased _____ Mother: ☐ Alive ☐ Deceased _____

Siblings: _____ Grandparents: _____

Number of family deaths related to obesity _____ ☐ Adopted (history unknown)

Past Surgical History

Surgery	Year	Surgery	Year	Surgery	Year	Surgery	Year
		☐ Colectomy					
☐ AICD insertion		☐ Colostomy		☐ Liver biopsy		☐ Cesarean section	
☐ Angioplasty		☐ ESWL		☐ Nephrectomy		☐ D and C	
☐ Angio w/ stent		☐ Gastric bypass		☐ Organ transplant		☐ Hysterectomy	
☐ Appendectomy		☐ Gender reassignment		☐ ORIF		☐ Mastectomy	
☐ Arthroscopy knee		☐ Hemorrhoidectomy		☐ Pacemaker		☐ Myomectomy	
☐ Back surgery		☐ Herniorrhaphy		☐ Small bowel resection		☐ Penile implant	
☐ Breast biopsy		☐ Hip replacement		☐ Thyroidectomy		☐ Prostate biopsy	
☐ tubal ligation		☐ Knee replacement		☐ Tonsillectomy		☐ TAH/BSO	
☐ CABG		☐ Laparoscopy		☐ Valve replacement		☐ TURP	
☐ Carpal tunnel		☐ Laparotomy		Gender Specific		☐ Vasectomy	
☐ Cataract extraction		☐ Lap band		☐ Breast augmentation		☐ Other:_____	
☐ Cholecystectomy		☐ LASIK		☐ Breast reduction		☐ Other:_____	
☐ Other:_____		☐ Other:_____		☐ Other:_____		☐	

Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use ☐ Never ☐ Quit/ Year _____ ☐ Current smoker / packs per day _____ ☐ Other Tobacco

Alcohol Use ☐ Never ☐ Occasionally ☐ Moderate ☐ Daily/ How Much? _____

Drug Use ☐ Never ☐ Type & Frequency _____

Caffeine Use ☐ No ☐ Yes _____Cups per day ☐Coffee ☐Tea ☐Soda

Exercise ☐ None ☐ Yes Type & Frequency _____

Occupation ☐ Retired ☐ Current Occupation _____

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Previous Diet Attempts (Mark all that apply)

☐ NO DIET ATTEMPTS	☐ Alli-(Xenical) What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Meridia What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Fen- Phen What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Optifast What year:_____ Length of time on this diet:_____ Total Wgt Loss ___lbs
☐ Hypnosis What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Phentermine (Adipex) What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ National Weight Loss What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ LA Weight Loss What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Nutrisystem What year:_____ Length of time on this diet:_____ Total Wgt Loss ___lbs
☐ Atkins What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Slim fast What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Calorie Counting What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ T.O.P.S. What year:_____ Length of time on diet:_____ Total Wgt Loss ___lbs	☐ Weight Watchers What year:_____ Length of time on this diet:_____ Total Wgt Loss ___lbs

Allergy History ☐ No Known Drug Allergies

_____

Current Medication ☐ **See attached Med List** ☐ **No Medication at this time**

Medication Name and Strength	Directions	Prescribed by
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	
	Take ____ tab/cap ____ times per day	

Pharmacy: ***(Name and Phone number)*** _____

Advance Directive/Living Will ☐ **No** ☐ **Yes**

Healthcare Surrogate/Power of Attorney ☐ **No** ☐ **Yes Name:** _____

Patient Statement **To the best of my knowledge, the above information is accurate and complete.**

Signed: _____ **Date** _____