
Medical History

Date _____

Name _____ Social Security Number _____ - _____ - _____

DOB _____ Age _____ Height _____ Weight _____ BMI _____

Primary care doctor _____

For office use only

Height _____ Weight _____ BMI _____ Neck _____ Goal _____ Ideal _____

BMI>45 _____ Age>38 _____ Apnea _____ HbA1c _____ Insulin _____ Male _____

Past Medical History

Please circle the appropriate response

Bleeding	yes	no	Blood clots in the legs	yes	no
Rheumatic fever	yes	no	Blood clots to the lungs	yes	no
Thyroid problems	yes	no	Diabetes currently	yes	no
Tuberculosis	yes	no	Diabetes while pregnant	yes	no
Urinary tract infections	yes	no	Age at onset of diabetes	_____	
Kidney disease	yes	no	Diabetes control	good	poor
Hepatitis	yes	no	Polycystic ovarian syndrome (PCOS)	yes	no
Do you have to take antibiotics before dental work	yes	no	Problems with anesthesia	yes	no
AIDS/HIV	yes	no	Hypertension (high blood pressure)	yes	no
			High cholesterol or triglycerides	yes	no

Past Surgical History

Please list all surgeries and approximate dates (year)

Past Hospitalizations

Please list all hospitalizations and approximate dates (year)

Review of Symptoms

General			Infection		
Fevers	yes	no	HIV	yes	no
Sweats	yes	no	AIDS contact	yes	no
Fatigue	yes	no	TB exposure	yes	no
Loss of appetite	yes	no	Swollen glands	yes	no
Bloody sputum	yes	no	Recurring infections	yes	no
Persistent cough	yes	no	Skin infections	yes	no
Skin			Exercise Limitations		
Rash	yes	no	Mild	yes	no
Skin cancer	yes	no	Moderate	yes	no
Senses			Severe	yes	no
Visual problems	yes	no	Pain in joints		
Hearing problems	yes	no	Back	yes	no
Ear ringing	yes	no	Hips	yes	no
Neurological			Knees	yes	no
Dizziness	yes	no	Feet	yes	no
Migraines	yes	no	Arthritis		
Seizures	yes	no	Where	_____	
Strokes	yes	no	Gastrointestinal		
Memory loss	yes	no	Heartburn/acid reflux	yes	no
Shaking	yes	no	Stomach pains	yes	no
Numbness	yes	no	Stomach ulcers	yes	no
Uncoordination	yes	no	Gastritis	yes	no
Genito-urinary			H. pylori infection	yes	no
Blood in urine	yes	no	Rectal bleeding	yes	no
Vaginal infections	yes	no	Liver disease	yes	no
Stress urinary incontinence	yes	no	Hepatitis or cirrhosis	yes	no
Bladder/kidney infections	yes	no	Colitis or enteritis	yes	no
Prostate infections	yes	no	Stomach surgery	yes	no
Sleep apnea			Physical limitations		
Snoring	yes	no	Climbing stairs	yes	no
Require C-pap	yes	no	Unusual fatigue	yes	no
Daytime drowsiness	yes	no	Airline travel	yes	no
Frequent waking at night	yes	no	Lifting from floor	yes	no
Choking at night	yes	no	Use of public seating	yes	no
# of pillows used	_____		Personal care	yes	no
Pulmonary disease			Tying shoelaces	yes	no
Short of breath on exertion	yes	no	Playing with children	yes	no
Hay fever	yes	no	Gynecological		
Emphysema/COPD	yes	no	Last menstrual period	_____	
Asthma	yes	no	Pregnancies	_____	
Aspiration/choking	yes	no	Current contraception	_____	
			Any chance you are currently pregnant	yes	no

Review of Symptoms (continued)

Cardiovascular			Psychological		
Heart attack	yes	no	Depression	yes	no
Congestive heart failure	yes	no	Feeling down	yes	no
Thrombophlebitis	yes	no	Suicidal episodes	yes	no
Swelling of ankles	yes	no	Mood swings for days at a time	yes	no
Chest pain	yes	no	Hospitalized for psychiatric reasons	yes	no
Coronary heart disease	yes	no	Use alcohol or drugs to cope	yes	no
Varicose veins	yes	no	Eating disorder	yes	no
Heart murmur	yes	no	Vomiting to lose weight	yes	no
Pulmonary embolism	yes	no	Fasting to lose weight	yes	no
Stroke	yes	no	Laxatives to lose weight	yes	no
Ever taken Fen-Phen	yes	no	Life more stable than a year ago	yes	no
			History of sexual abuse	yes	no
			Psychiatric medications in past or present	yes	no
			Overeat in reaction to feelings	yes	no
			Is your spouse or significant other supportive of weight loss surgery	yes	no
			Age you first became overweight	_____	

Epworth Sleepiness Scale

Note: the Epworth Sleepiness scale refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Scale	Situation	Likelihood
0 = would never doze	Sitting and reading	_____
1 = slight chance of dozing	Watching TV	_____
2 = moderate chance of dozing	Sitting, inactive in a public place	_____
3 = high chance of dozing	As a passenger in a car for 1 hour, no break	_____
	Lying down to rest in the afternoon when circumstances permit	_____
	Sitting and talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In a car, stopped in traffic	_____

Medications

List all daily medications including over-the-counter medications and vitamins, herbs or supplements

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	No

Allergies

Please list any known allergies or sensitivities

Medication allergies

Other allergies

Sensitive or allergic to

Latex	yes	no	Iodine	yes	no
Dye	yes	no	Tape	yes	no

Social History

Marital status Single Married/Partnered Divorced/Separated Widowed

Religious preference _____

Education _____

Number of people living in your home _____

What type of work do you do _____

Do you smoke	yes	no	Do you drink alcohol	yes	no
How many per day	_____		How many per day	_____	
How much and how often	_____		How much and how often	_____	
Do you use controlled substances				yes	no

How does your spouse or partner feel about weight loss surgery _____

Family History

Disease	Who in your family had it	When	Was it fatal
Cancer (what type)			
Diabetes			
Heart attack			
Severe obesity			
Other			

Weight Loss History

Please check all that apply.

Non-Supervised Attempts

Body For Life/Bill Phillips	
Gloria Marshall	
Health spa	
High protein	
Hypnosis	
Low carbohydrate	
Low fat	
Calorie counting on my own	
Gym membership	
Home gym equipment	

Atkins Diet	
AYDS	
Mayo Clinic Diet	
Pritikin	
Richard Simmons	
Scarsdale Diet	
Stillman Diet	
Sugar Busters	
Slim Fast	
South Beach Diet	
Other	

Supervised Weight Loss Attempts

Diet Pills From MD	
Diet Shots From MD	
Diet Center	
Overeaters Anonymous	
Optifast	
Weight Watchers	
Health Management Resources (HMR)	
Nutri-System	
T.O.P.S.	
Jenny Craig	
New Direction	
National Weight Loss	

Supervised Calorie Counting	
Acupuncture	
Psychological Counseling	
Weigh Of Life	
Weight Loss Center	
Exercise Counseling	
Medifast	
Metrical	
Nutritional counseling	
Personal Trainer	
Other	

Weight Loss Medications

Acutrim	
Adipex-P	
Amphetamines	
Anorex	
Benzphetamine	
Dexatrim	
Didrex	
Fastin	
Fenfluramine	
Herbal Remedies	
Ionamin	
Mazanor	
Meridia	
Metabolife	

Obalan	
Orlistat	
Phendiet	
Phentermine	
Phentrol	
Plegine	
Pondimin	
Redux	
Sanorex	
Tepanol	
Tenuate	
Wehless	
Xenical	
Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)	
Stomach stapling	
Vertical banded gastroplasty	

Gastric band	
Other	

Nutrition History

How many meals do you eat daily	<hr/>	
Do you snack between meals	yes	no
Do you drink soda	yes	no
Diet	yes	no
Regular	yes	no
How many sodas do you drink daily	<hr/>	

Food Preferences

Candy	yes	no	Fast food	yes	no
Cookies	yes	no	Seafood	yes	no
Fried food	yes	no	Cakes or pies	yes	no
Pizza	yes	no	Vegetables	yes	no
Chocolate	yes	no	Steak or red meat	yes	no
Chips and snacks	yes	no	Dairy products	yes	No
Food allergies	<hr/>				

Food Patterns

Please record the type of food and the amount you have eaten over the past two days.

	All foods eaten yesterday	All foods eaten the day before yesterday
Before breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon snack		
Dinner		
After dinner		
Before bed		
Other		

Patient Experience Questionnaire

How did you hear about the Lap-Band?

How did you hear about Dr. Goldstein?

Why have you chosen the Lap-Band procedure rather than other weight loss surgery?

When and where did you attend the information session?

Did the information session influence your decision regarding the Lap-Band? If so, how?

Is there anything about the information session that you would change?

How would you improve your experience thus far with either Dr. Goldstein's practice or the New Beginnings program?

Do you use the internet to research topics that you are interested in? If so, what sites do you use?

Do you subscribe to any of the following: SJ Magazine, South Jersey Magazine, Philadelphia Magazine, or other magazines?

What newspaper(s) do you subscribe to? Do you read the "Sun" newspapers (Cherry Hill, etc.)?

What is/are your favorite radio station(s)?