Premier Weigh Loss Center
2381 S. Melrose Drive
Vista, CA 92081
760-300-3647

WEIGHT LOSS PROGRAM

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (M.I) _____

Home Address: _____ (City) _____ (Zip) _____

Phone#: Home: _____ Work: _____

Cell: _____ Email Address: _____

Birth date: _____ Age: _____ SS#: _____ Sex: ☐Male ☐Female

Status: ☐Married ☐Single ☐Widowed ☐Divorced *Ethnicity*: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Decline to report

Primary Language Spoken: ☐English ☐Spanish ☐Other: _____

Primary Care Doctor: _____ Referring Doctor: _____

Employer Name: _____ Occupation: _____

Do you work ☐Full-time ☐Part-time ☐Retired Is this a Worker's Compensation Injury? ☐Yes ☐No

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

Home Address: _____ (City) _____ (Zip) _____

Phone#: Home: _____ Work: _____

Cell: _____ Email Address: _____

INSURANCE INFORMATION

Please provide us with your insurance card so that we can make a photocopy

Primary Insurance Name: _____ ☐HMO ☐PPO

Name of Medical Group: _____

Member ID#: _____ Group#: _____

Subscriber Name: (Last) _____ (First) _____ (M.I.) _____

Subscriber Birth date: _____ Subscriber SSN#: _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

ADDITIONAL INSURANCE INFORMATION

Please provide us with your insurance card so that we can make a photocopy

Insurance Name: _____ ☐HMO ☐PPO

Name of Medical Group: _____

Member ID#: _____ Group#: _____

Subscriber Name: (Last) _____ (First) _____ (M.I.) _____

Subscriber Birth date: _____ Subscriber SSN#: _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other

PATIENT HISTORY QUESTIONNAIRE
(Please Print)

The information requested in this questionnaire is very important. To give you the best care, we must have complete answers. Please be thorough. Please print clearly and use blue or black ink only.

Please record estimated height and weight.

HEIGHT	WEIGHT

Weight History

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth Weight:		
Start of High School:		
High School Graduation:		
Marriage:		
Lowest Weight in Past 5 years:		
Highest Weight in Past 5 years:		

What is your Goal Weight? _____

How long have you been contemplating bariatric surgery? _____

Have you done any research regarding bariatric surgery? ☐Yes ☐No

If yes, what type? _____

Do you have a friend or family member who has had bariatric surgery? ☐Yes ☐No

Who? _____

How did you hear about this program? _____

DIETING HISTORY:

Age you first started dieting: _____

PROGRAM	YES	NO	DATE(S)	DURATION	MAX LOSS	MD SUPERVISED?
ACUPUNCTURE						
ALLI						
ATKINS						
Calorie Counting						
FEN/PHEN or REDUX						
JENNY CRAIG						
MERIDIA						
METABOLIFE						
NUTRI-SYSTEMS						
OPTI-FAST or MEDI FAST						
OVER THE COUNTER DIET AIDS						
RICHARD SIMMONS						
SOUTH BEACH DIET						
T.O.P.S.						
WEIGHT WATCHERS						
XENICAL						
Other Prescription/Shots						

List any other physician-supervised and documented weight loss attempt:

_____

_____

_____

What was the most successful weight loss you have achieved and how did you do it?

_____

_____

_____

What behaviors did you learn from dieting that you still use today?

_____

_____

_____

FOOD INTAKE: PLEASE FILL OUT THE ATTACHED 3-DAY FOOD JOURNAL

How many meals do you consume per day? _____

Do you snack between meals? ☐Yes ☐No
If so, what? _____
How often? _____

Is snacking from habit? ☐Yes ☐No Depression? ☐Yes ☐No
Boredom? ☐Yes ☐No Do you binge eat? ☐Yes ☐No
If so, what? _____
How often? _____

Do you have any diet restrictions?

Vegan? ☐Yes ☐No
Vegetarian? ☐Yes ☐No
Lactose intolerant? ☐Yes ☐No
Gluten Free? ☐Yes ☐No
Other? _____

FOOD FREQUENCY: Please write the serving size of each food consumed in the appropriate box depending on if you eat the food daily, weekly, or monthly. For example, if you consume 1 serving of ½ cup of vegetables per day, you would write ½ cup under the "per day" column for vegetables.

Food	Never	Per Day	Per Week	Per Month
Vegetables (NOT including corn, potatoes, and peas)				
Corn, potatoes, and peas				
Fruit				
Fish				
Meat				
Full fat dairy (whole milk and cheese)				
Fried Foods				

Beans				
Bread				
Pasta				
Pizza				
Sweets (candy bars, cookies, cakes, ice cream etc.)				
Nuts				
Sweetened Beverages (juice, soda, sports drinks etc.)				
Chips				
Alcohol				
Fast Food/Restaurant Meals				

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following. Check or circle all that apply.

CARDIOVASCULAR	**YES**	**NO**	**DON'T KNOW**	**GASTROINTESTINAL**	**YES**	**NO**	**DON'T KNOW**
Heart Disease				Do you experience heartburn or regurgitation?			
MI (Heart Attack)				How many times per week?			
Abnormal EKG				List medications on page 4			
Have you ever had a stress test?				**URINARY**			
Have you ever had an echocardiogram?				Difficulty with urination?			
List reason for above:				Frequent Bladder infections?			
High Blood Pressure:				Incontinence?			
Do your legs/ankles become swollen easily?				Kidney disease or frequent infections?			
List medications on page 4				**GYNECOLOGICAL**			
ENDOCRINE				Last menstrual period:			
Are you a Diabetic?				Number of pregnancies:			
Average daily blood sugars:				Number of birth(s):			
Do you oral medications?				Last mammogram: Date:			
Do you use Insulin?				Was it normal?			
Do you have thyroid				Last PAP smear: Date:			

problems?							
Elevated Cholesterol?				Was it normal or abnormal?			
List medications on page 4				Are you taking hormones? (Birth control or Hormone Therapy)			
RESPIRATORY				**HEMATOLOGICAL**			
Do you have asthma?				Do you have a bleeding abnormality?			
Do you use inhalers?				If so, describe:			
Do you take oral medications for Asthma? If so, list medications on page 4				Have you ever had a blood transfusion?			
Shortness of breath?				If so, reason:			
How far can you walk before feeling short of breath?				History of blood clots? (DVT or pulmonary embolism)			
Do you smoke?				Date & Treatment:			
If yes, how much per day?				AIDS/HIV exposure?			
SLEEP APNEA				**MUSCULOSKELETAL**			
Do you use a C-PAP or Bi-PAP device?				Back or Hip Pain?			
PSYCHOLOGICAL				Knee, Ankle or Foot Pain?			
Depression				Which of these is the worst?			
Panic Attacks				Have you seen an Orthopedic Physician for any of the above?			
Anxiety				Have you had surgery for any of the above?			
Bi-polar Disease				Is orthopedic surgery pending weight loss?			
Obsessive Compulsive Disorder				**OTHER**			
Currently seeking therapy:				Antibiotic resistant organisms?			
List medications on page 7				Hepatitis			

Family Medical History: _____

_____

Surgeries/procedures:

Surgery/Procedure	Date	Doctor

Allergies:

Allergies to any Medications: ☐Yes ☐No Type: _____
Allergies to any Foods: ☐Yes ☐No Type: _____
Allergic to Latex: ☐Yes ☐No
Surgical tape: ☐Yes ☐No
Steri-Strips: ☐Yes ☐No

Iodine: ☐Yes ☐No
Tega-Derm: ☐Yes ☐No

Other Allergies (Please list)	Reaction

Medication:

Medication	Dosage	Frequency	Comments	Update

Please attach medication list if applicable

ADDITIONAL MEDICAL QUESTIONS:

If Heart Disease – any history of CABG (bypass surgery?) ☐Yes ☐No
When? _____

Stents? ☐Yes ☐No When? _____
Pacemaker? ☐Yes ☐No
Diabetes? ☐Yes ☐No Last fasting glucose? _____ HgA1C? _____
Asthma? ☐Yes ☐No
Any hospitalizations I the last 2 years for asthma? ☐Yes ☐No
Steroids in last 2 years? ☐Yes ☐No
Sleep Apnea? ☐Yes ☐No
Do you snore? ☐Yes ☐No
Stop breathing while sleeping? ☐Yes ☐No
Last sleep study? _____

Please identify any of the following childhood illnesses you have experienced?

Measles? ☐Yes ☐No Mumps? ☐Yes ☐No
Chickenpox? ☐Yes ☐No Rheumatic Fever? ☐Yes ☐No
Asthma? ☐Yes ☐No Tonsillectomy? ☐Yes ☐No

Female patients:

Number of pregnancies? _____ Age at first period? _____
Number of live births? _____ Date of last period? _____
Miscarriages/Abortions? _____ Obstetrical complications? _____
Last Pap? _____ Last mammogram? _____
Any Contraceptive method? ☐Yes ☐No Which kind? _____

Patients over 50:

Colonoscopy? ☐Yes ☐No Date? _____ Findings? _____

SOCIAL/FAMILY HISTORY:

Is there Obesity in the family? ☐Yes ☐No Who: _____

Are there any medical illnesses in your family? ☐Yes ☐No If so, what: _____
Diabetes ☐Yes ☐No Hypertension ☐Yes ☐No
Coronary Artery Disease ☐Yes ☐No
Other: _____
_____

Do you exercise regularly? ☐Yes ☐No If yes, what do you do? _____

Do you have any physical restrictions that keep you from exercising? ☐Yes ☐No
Explain? _____

SMOKING/ALCOHOL/DRUG HISTORY:

Do you smoke? ☐Yes ☐No How often? _____ ☐Heavy smoker ☐Light smoker
Do you / did you drink alcohol? ☐Yes ☐No How much? _____ ☐Beer ☐Liquor ☐Wine
☐Socially ☐Minimally ☐Infrequently ☐Frequently
Drug Use? ☐Yes ☐No Type: _____

SOCIAL AND FAMILY HISTORY:

Do you have a history of abuse? (Please indicate emotional, physical, mental, substance or other types of abuse issues you've dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan):

_____

_____

_____

Describe your present life stressors: _____

_____

Describe the present support system you rely on. (Church, spouse, family, friends, co-workers, etc):

What is your greatest fear regarding potential surgery?

What is your greatest hope regarding surgery?

What are your goals regarding the surgery?

What is motivating you to seek this type of intervention for weight control and/or loss?

LIST ALL YOUR CURRENT PHYSICIANS: (PLEASE COMPLETE)

SPECIALTY	NAME	ADDRESS	PHONE & FAX NUMBERS
PRIMARY CARE/ INTERNAL MEDICINE			
GYN			
ORTHOPEDIC			
ENDOCRINOLOGIST			
PSYCHOLOGIST/ PSYCHIATRIST/ THERAPIST			
CHIROPRACTOR			
INTERNIST			
CARDIOLOGIST			
PULMONOLOGIST			
OTHER			

I certify that all of the information that I provided on this questionnaire is true, accurate, and complete.

Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Check any of the following that you have had, or have presently:

General:
☐Fevers
☐ Chills
☐ Sweats
☐ Anorexia
☐ Fatigue
☐ Sleepiness
☐ Sleep Problems
☐ Malaise
☐ Weight Gain/Loss

Eyes:
☐ Pain
☐ Vision Loss
☐ Excessive Tears
☐ Blurred Vision
☐ Double Vision
☐ Irritation
☐ Discharge
☐ Photophobia

Ears/Nose/Throat:
☐ Ear pain/Infection
☐ Discharge
☐ Decreased hearing
☐ Nasal obstruction
☐ Nasal discharge
☐ Nosebleeds
☐ Sore Throat

Cardiovascular:
☐ Chest pain
☐ Palpitations
☐ High Blood Pressure
☐ Heart Murmur
☐ Irregular Heartbeat
☐ Swelling of Legs
☐ Use of Oxygen

Respiratory:
☐ Cough
☐ Dyspnea
☐ Excessive Sputum
☐ Wheezing
☐ Shortness of Breath

Gastrointestinal
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Abdominal pain
☐ Constipation

Genitourinary
☐ Urinary Symptoms
☐ Painful Urination
☐ Urinary Frequency
☐ Discharge
☐ Sores
☐ Menstrual Irregularity

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Cramps
☐ Muscle Weakness
☐ Stiffness

Skin
☐ Rash
☐ Itching
☐ Ulcers/growths
☐ Excess Scarring
☐ Bleeding Problem
☐ Dryness
☐ Suspicious Lesions

Neurologic
☐ Transient Paralysis
☐ Weakness
☐ Seizures
☐ Tremors
☐ Vertigo
☐ Frequency or Severe Headaches

Psychiatric:
☐ Depression
☐ Anxiety
☐ Memory Loss
☐ Mental Disturbance
☐ Suicidal Ideation
☐ Hallucinations
☐ Paranoia

Endocrine
☐ Cold Intolerance
☐ Heat Intolerance
☐ Excessive/Increased Thirst
☐ Tired/Sluggish

Hematologic/Lymphatics
☐ Abnormal Bruising
☐ Bleeding
☐ Enlarged Lymph nodes
☐ Blood Clotting Problems
☐ Anemia

Allergic/Immunologic:
☐ Hay Fever
☐ Persistent Infections
☐ Drug Allergies

GYN (Females only)
☐ Symptomatic Hot
☐ Flashes
☐ Symptomatic Vaginal
☐ Dryness
☐ Difficulty Sleeping
☐ Mammogram(past year)
☐ Pap Smear(past year)

Health Screening:
☐ Colonoscopy(past year)
☐ Other: _____
_____

Additional comments:____
_____
_____

☐ **NONE of the above apply to my present condition.**