

St. Joseph Surgical Weight Loss Center
1600 Joseph Drive
Bryan, Texas 77802

979-821-7556
800-914-0745
Fax 979-821-7587

PATIENT INFORMATION

Last name, first, middle initial			Date of Birth	Sex	Marital Status M D S W	
Street Address			Home Phone		Email Address	
City	State	Zip code	Work Phone		Cell Number	
Employer's Name			Driver's License Number and State in Which Issued			
Employer's Street Address			Social Security Number			
City	State	Zip code	Occupation			
Emergency Contact:		Relationship	Religious Preference		Do you smoke?	
Street Address			Home Phone		Work Phone	
City	State	Zipcode	<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Indian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other			

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Name of Insured	Name of Insured
Relationship to Patient	Relationship to Patient
Insured's Employer	Insured's Employer

How did you hear about us?
 (Circle one and complete information)

Community Lecture Date: _____ Doctor: _____
 Friend Name: _____
 Internet Other: _____

Surgeon Preference: _____ Surgery Type: _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original. I understand and consent that information relating to my bariatric surgery will be shared between St. Joseph Regional Health Center and my surgeon's office. My information will also be utilized in outcomes reporting and my identity will be protected according to the HIPPA rules and regulations.

Signature: _____ Date: _____

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CURRENT STATISTICS
(Please complete all information except shaded items)

Name:		Date:	
Age:	Gender: Male Female	Occupation:	
Height:	Your Measurement:	<i>1st Office Visit Measurement:</i>	<i>Pre-Operative Measurement:</i>
Current Body Weight:			
Current BMI:			
Personal Target Weight:			
Personal Target BMI:			
Body Measurements: Waist Hip Waist/Hip Ratio			
Body Frame:	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large		

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program		Dates	Duration	Physician Supervised?	Max Loss
Jenny Craig	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Opti/Medi Fast	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Pritkins Diet	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Sugar Busters	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Metabolife	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Herbalife	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
South Beach	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Overeaters Anonymous	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Grapefruit Diet	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Slimfast/Liquid Diet	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____

List any physician-supervised and documented weight loss attempt:

List all other diets and/or weight loss attempts:

For female patients only:

Pregnancy #1	year _____	weight at start _____	at delivery _____
Pregnancy #2	year _____	weight at start _____	at delivery _____
Pregnancy #3	year _____	weight at start _____	at delivery _____
Pregnancy #4	year _____	weight at start _____	at delivery _____

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet:

Rank each selection from **1- like very much** to **4 – don't care**

_____ soda/ soft drinks	_____ french fries	_____ chips/snacks
_____ steaks/chops	_____ candy	_____ potatoes
_____ chocolate	_____ pasta	_____ cookies
_____ pizza	_____ cakes/pies	_____ salad dressings
_____ fried foods	_____ milk	_____ juice
_____ beer	_____ wine	_____ cocktails

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Eating Habits

Indicate which pattern best describes the way you eat:

- | | | |
|--|--|--|
| <input type="checkbox"/> 3 meals/day | <input type="checkbox"/> 2 meals/day | <input type="checkbox"/> graze all day (5 or more meals/day) |
| <input type="checkbox"/> usually eat breakfast | <input type="checkbox"/> usually skip breakfast | <input type="checkbox"/> usually eat lunch |
| <input type="checkbox"/> usually skip lunch | <input type="checkbox"/> eat very little on some days, a lot on other days | |
| <input type="checkbox"/> other | | |

How often do you binge eat? Daily Weekly Monthly Occasionally

Medications

List the weight loss medications you have taken :

		Dates	Duration	Physician Supervised?	Max Loss
Amphetamines	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Phentermine	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Phen-Fen	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Dexfenfluramine (Redux)	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Xenical (Orlistat)	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Meridia	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Lindora	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		
Other Diet Medications?	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____		

List the alternate therapies you have tried:

Program		Dates	Duration	Physician Supervised?	Max Loss
Acupuncture	yes <input type="checkbox"/> no <input type="checkbox"/>				
Hypnosis	yes <input type="checkbox"/> no <input type="checkbox"/>				
Biofeedback	yes <input type="checkbox"/> no <input type="checkbox"/>				
Behavior Modification	yes <input type="checkbox"/> no <input type="checkbox"/>				
Exercise	yes <input type="checkbox"/> no <input type="checkbox"/>				

List all exercise programs you have tried:

List any previous weight loss surgeries:

Surgery	Date	Location	Surgeon	Weight Loss
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease

yes no

• year diagnosed: _____

(check all that apply to you)

- Angina
- M.I. (myocardial infarction)
- CABG (coronary artery bypass graft)
- Abnormal EKG
- Stress test to rule out cardiac problems
- Palpitations

2. High Cholesterol

yes no

• year diagnosed: _____

• list medications: _____

• high triglycerides: _____

yes no

3. High Blood Pressure

yes no

• year diagnosed: _____

• average blood pressure: _____

• list medications: _____

• list dietary restrictions: _____

4. Diabetes

yes no

• year diagnosed: _____

• gestational: _____

yes no

• juvenile onset: _____

yes no

• adult onset: _____

yes no

• neuropathy: _____

yes no

• controlled with: _____

diet

insulin

oral medication (list below)

• last fasting blood sugar: _____

5. Asthma

yes no

• year diagnosed: _____

• ER visits in last 2 years: _____

• hospitalizations in last 2 years: _____

• steroids used in last 2 years: _____

yes no

6. Shortness of breath

yes no

• can walk on level ground –

how far: _____

yes no

how many stairs: _____

blocks

flights

7. Sleep apnea

yes no

• year diagnosed: _____

• last sleep study: _____

month/year

• CPAP or BiPAP used:
machine settings: _____

yes no

• morning headaches: _____

yes no

• daytime drowsiness: _____

yes no

• restless sleep: _____

yes no

• snoring: _____

yes no

• awakenings at night: _____

yes no

• observed apneic episodes: _____

yes no

8. Obesity hyperventilation syndrome? yes no

9. Coughing or choking at night? yes no

10. Heartburn/ esophagitis/hiatal hernia? yes no

- year diagnosed: _____
- upper GI series? yes no
- endoscopy? yes no
- medications & frequency of use: _____

11. Belching acid or sour fluid in back of throat? yes no

12. Gallbladder disease? yes no

- How was it diagnosed? ultrasound physical exam

13. Urinary incontinence? yes no

- With coughing/sneezing/laughing? yes no
- Wears pads frequently? yes no

14. Low Back Pain/Sciatica? yes no

- Limits ability to walk or exercise
- Medications , frequency & dosage: _____

15. Joint pain? yes no

- Hips yes no
- Knees yes no
- Ankles yes no
- Feet yes no

- Medications, frequency & dosage: _____

- Limits ability to walk or exercise yes no

16. Weight related injuries and trauma: _____

17. Venous stasis disease? yes no

- Leg/ankle swelling yes no
- Leg ulceration yes no
- Skin colored/thickened yes no

18. Thyroid disease? yes no

19. Migraine headaches? yes no

- Medications, frequency & dosage: _____

FAMILY HISTORY

Family Member	Living?	Age	Obese?	Deceased at age	Illness/Cause of death
Mother	yes <input type="checkbox"/> no <input type="checkbox"/>				
Father	yes <input type="checkbox"/> no <input type="checkbox"/>				
Maternal Grandmother	yes <input type="checkbox"/> no <input type="checkbox"/>				
Maternal Grandfather	yes <input type="checkbox"/> no <input type="checkbox"/>				
Fraternal Grandmother	yes <input type="checkbox"/> no <input type="checkbox"/>				
Fraternal Grandfather	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Sibling	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				
Child	yes <input type="checkbox"/> no <input type="checkbox"/>				

Please check if there is a family history of:

- | | |
|---|--|
| <input type="checkbox"/> obesity | <input type="checkbox"/> lung disease, asthma or emphysema |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> bleeding tendency or blood disorder |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> breast cancer |
| <input type="checkbox"/> high blood cholesterol | <input type="checkbox"/> colon cancer |
| <input type="checkbox"/> stroke | <input type="checkbox"/> other cancers |
| <input type="checkbox"/> blood disorder | <input type="checkbox"/> other (please specify) _____ |

Please list all the physicians whose care you are under:

	Name	Address	Phone Number
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Other	_____	_____	_____

Have you ever been hospitalized for mental illness? yes no

Have you ever been treated for depression? yes no

Are you currently in treatment? yes no

SYSTEM REVIEW:

Circle all symptoms, which you have, or have had. Write in any additional problems.

CONSTITUTIONAL:

fatigue, tiredness, fever, night sweats, recent weight loss, abnormal bleeding

HEAD, EYE, EAR, NOSE & THROAT:

stuffy nose, runny nose, hay fever, sinus congestion, sinus infection, sneezing, earache, headache, blurry vision, double vision, haloes around lights, loss of vision, loss of night vision, buzzing in ears, ringing in ears, discharge from ear, loss of hearing, dizziness, vertigo, loss of balance, sore throat, lump in throat, trouble swallowing, pain with swallowing, hoarseness, loss of smell, lump in neck

RESPIRATORY:

cough, wheezing, shortness of breath at night, use two pillows, blood in sputum, out of breath with exertion, wake up at night short of breath, wake up at night coughing or choking, asthma, emphysema, bronchitis, pneumonia, difficulty sleeping flat

CARDIOVASCULAR:

palpitations, pounding of heart, skipping of heartbeat, pains in chest, pains in neck, pains in arms, squeezing of chest, heart attack, heart murmur, abnormal electrocardiogram, irregular heartbeat, high blood pressure, low blood pressure, pain in legs, cold feet, blue toes, blue fingers, loss of pulses, stroke

GASTROINTESTINAL:

heartburn, nausea, vomiting, belching fluid in throat, burning in throat, food sticking in chest, pains in stomach, burning in stomach, acid stomach, diarrhea, constipation, pain with bowel movement, blood in stools, change in stool size, hemorrhoids, fissures, cramps, gassiness, irritable colon, colitis, jaundice, hepatitis, cirrhosis

GENTOURINARY:

pain with urination, trouble starting urine, trouble stopping urine, small urine stream, blood in urine, kidney stones, bladder stones, bladder infection, kidney infection, kidney failure, nephritis, urinary tract infections, frequent urination, getting up at night to urinate, leakage of urine with cough or sneeze

MEN: discharge from penis, loss of erection, painful erection

WOMEN: vaginal discharge, abnormal vaginal bleeding, pain with intercourse, irregular periods, pelvic examination/pap smear within past year

ENDOCRINE (GLANDULAR):

low thyroid, hyperthyroid, goiter, Grave's disease, thyroid nodules, X-ray to thyroid, diabetes, swollen glands, adrenal gland tumor, frequent flushing, frequent heavy sweating, previous steroid use or injections (corticosteroids or cortisone)

MUSCULOSKELETAL:

pain in joints, swelling of joints, redness of skin over joints, warm joints, fluid in joints, arthritis, broken bones, sprains, low back pain, hip pain, knee pain, ankle pain, foot pain, flat feet, slipped disk, herniated disk, sciatica, numbness in feet or legs, muscle pain, abnormal lumps or masses

NEUROLOGICAL:

dizziness, vertigo, light headedness, falling, falling to side, falling at night, numbness, tingling, pins and needles feelings, weakness of any muscles, twitching of muscles, weakness of grip, shakiness, tremors, fainting, convulsions, fits, seizures, loss of consciousness

PSYCHOLOGICAL:

nervousness, anxiety, depression, thoughts of suicide, suicide attempts, hospitalizations for emotional problems, psychiatric treatment, psychological counseling, anorexia, bulimia, binge eating, schizophrenia