



ST. JOHN WEIGHT LOSS CENTER

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HEALTH HISTORY PROFILE

Please complete the following pages thoroughly. The information contained within this form will be used to provide the best care for you and to obtain insurance authorization for your procedure.
 (Please print)

NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

Day time phone #: _____

WEIGHT HISTORY

Life Event	Age	Weight
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		
1 st Pregnancy		
Last Pregnancy		

PAST WEIGHT LOSS ATTEMPTS

Diet Name	Year	Length of Time	Weight Lost	Weight Regained
	Last 6 months			
	This Year			
	Last Year			
	2 Years Ago			

When did you last visit a physician? _____

How many years have you attempted weight loss? _____

Have you ever had any form of weight loss surgery? YES NO If yes, please list procedure and date:

Are you currently following a special diet and/or exercise program? If yes please list details:

PATIENT NAME: _____

Drug treatment prescribed by a physician (Meridia, Xenical, Redux etc...)

Name of drug: _____ Duration: _____

Weight Lost: _____ Weight Regained: _____

Reason medication was stopped: _____

Have you ever taken Phen-Fen OR Redux? Yes No If yes, did you have an echocardiogram? Yes No

Inpatient weight loss program: Name: _____

Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Diet Shots Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Medically Supervised Weight Loss: Name of physician or program: _____

Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Medifast Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Nutritionist Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Optifast Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Other Forms of Weight Loss

Acupuncture Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Appetite Suppressants Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Atkins Diet Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Body Solutions Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Cabbage Soup Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Exercise Videos Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Gastric Bubble Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Gym Membership/Trainer- Name of gym: _____

Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Herbalife Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Hypnosis Duration: _____ Pounds Lost: _____ Pounds Regained: _____

Jaw Wiring Duration: _____ Pounds Lost: _____ Pounds Regained: _____

PATIENT NAME: _____

- Jenny Craig Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- LA Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Low Carbohydrate Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Low Cholesterol Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Mayo Clinic Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Metabolife Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- NutriSystem Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Over Eater's Anonymous Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Pritikin Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Reduced Calorie Diet 1000/1500/1800
Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Richard Simmons Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Scarsdale Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Slim Fast Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- South Beach Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Sugar Busters Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- T.O.P.S. Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Vegetarian Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Weight Watchers Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- Zone Diet Duration:_____ Pounds Lost:_____ Pounds Regained:_____
- OTHER Name:_____ Duration:_____ Pounds Lost:_____ Pounds Regained:_____

PATIENT NAME:_____

SOCIAL HISTORY

Religion: _____ Level of Education: _____

Number of Persons Living in the Home: _____

Smoking History: Never Former Smoker Year Quit: _____

CURRENTLY Smoking Number of packs per day: _____ Number of years: _____

All patients who currently smoke are required to quit FOUR WEEKS prior to surgery

Recreational Drug Use: Yes No Describe: _____

Coffee/Caffeine Intake: Yes No _____ Cups per day

Carbonated Beverages: Yes No _____ Sodas per day

Alcohol Intake: Yes No _____ Drinks per day

Alcohol is not to be consumed TWO WEEKS prior to surgery

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses and operations you have experienced.

Rheumatic fever Year: _____ Heart murmur Year: _____

Obesity Year: _____ Bleeding disorders Year: _____

Appendectomy Year: _____ Tonsillectomy Year: _____

Asthma Year: _____

Female patients only

Do you have a regular Menstrual Cycle (26 - 33 days) Yes No

Excessively heavy Menstrual Cycle Yes No

Difficulty with Conceiving Yes No

Are you currently having problems with infertility Yes No

Have you ever been told by a doctor that you have polycystic ovaries Yes No

Have you had a caesarean section Yes No

Currently pregnant Yes No

PATIENT NAME: _____

Number of pregnancies: _____ Date of last period: _____
Number of live births: _____ Miscarriages/abortions: _____
Obstetric complications:

Do you presently use the following?

Birth control pills Yes No List Type: _____

IUD Yes No List Type: _____

Estrogens Yes No List Type: _____

Hormone Replacement Therapy
Yes No List Type: _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood.

<u>Major Illness</u>	<u>Date</u>	<u>Treatment</u>
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Major Surgery

_____ Year _____

_____ Year _____

_____ Year _____

Past surgical complications

Difficulty with anesthesia Yes No

Difficulty healing Yes No

Bleeding problems Yes No

Blood clots (Deep Vein Thrombosis or Pulmonary Embolism) Yes No

Pneumonia Yes No

PATIENT NAME: _____

Allergy to surgical tape/latex

Yes No

Have you ever had swelling, itching, or hives after being examined by medical professional wearing rubber or latex gloves?

Yes No

Are you allergic to seafood, eggs, iodine, nuts, or milk?

Yes No

Drug Allergies **Drug** **Reaction** _____ ✓ **Here if NONE**

FAMILY MEDICAL HISTORY

	PARENT	SIBLING	OTHER RELATIVES	NO FAMILY HISTORY	DON'T KNOW
Obesity					
Diabetes					
Heart Disease					
Hypertension					
High Cholesterol					
Sleep Apnea					
Asthma					
Stroke					
Cancer					
Blood clots					
Depression					
Osteoporosis					

WEIGHT RELATED ILLNESSES

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

CARDIOVASCULAR:

Varicose Veins Yes No Details: _____

Venous Stasis Disease Yes No Details: _____

PATIENT NAME: _____

Swelling of Ankles/Feet Yes No Details: _____

Deep Vein Thrombosis- DVT Yes No Details: _____
 (Blood clot in leg)

Pulmonary Embolism Yes No Details: _____
 (Blood clot in lung)

High Cholesterol Yes No Details: _____

High Triglycerides Yes No Details: _____

High Blood Pressure Yes No Details: _____

Palpitations Yes No Details: _____

Angina (chest pain) Yes No Details: _____

M.I. Yes No Details: _____
 (myocardial infarction, heart attack)

CABG Yes No Details: _____
 (coronary artery bypass graft, known as open heart surgery)

Cardiomyopathy Yes No Details: _____

Abnormal EKG Yes No Details: _____

Arrhythmia Yes No Details: _____

Shortness of breath Yes No Details: _____

Stress test to rule out cardiac problems Date: _____

Echocardiogram (heart ultrasound) Date: _____

ENDOCRINOLOGY:

Diabetes Yes No Details: _____

Do you take Insulin Yes No Details: _____

Oral Medication Yes No Details: _____

Diabetes with pregnancy Yes No Details: _____

Glucose Intolerance Yes No Details: _____

Hyperthyroidism Yes No Details: _____

Hypothyroidism Yes No Details: _____

Goiter Yes No Details: _____

Grave's Disease Yes No Details: _____

PULMONARY

Asthma Yes No Details: _____

Hospitalization in last 2 years Yes No Details: _____

Steroid use in last 2 years Yes No Details: _____

Do you snore? Yes No Details: _____

PATIENT NAME: _____

Do you wake at night with a choking feeling?

Yes No Details: _____

Do you have a headache when you wake up in the morning?

Yes No Details: _____

Do you feel sleepy during the day?

Yes No Details: _____

Have you ever been told you stop breathing in your sleep?

Yes No Details: _____

Sleep Apnea

Yes No Details: _____

CPAP or BiPAP

Yes No Details: _____

Year diagnosed: _____

Last sleep study: _____

Emphysema

Yes No Details: _____

Chronic Obstructive Pulmonary Disease (COPD)

Yes No Details: _____

GASTROINTESTINAL

Heart burn

Yes No Details: _____

Hiatal hernia

Yes No Details: _____

Ulcer

Yes No Details: _____

Gastritis

Yes No Details: _____

Constipation

Yes No Details: _____

Diarrhea

Yes No Details: _____

Colitis

Yes No Details: _____

Irritable Bowel Syndrome

Yes No Details: _____

Crohn's Disease

Yes No Details: _____

Hepatitis or Liver disease

Yes No Details: _____

Rectal Bleeding

Yes No Details: _____

GALLBLADDER

Gallbladder disease

Yes No Details: _____

Gallbladder removed

Yes No Details: _____

Ultrasound performed

Yes No Details: _____

GENITO-URINARY:

Renal / kidney failure

Yes No Details: _____

Leakage of urine with
laughing/coughing/ sneezing

Yes No Details: _____

Wear pads frequently

Yes No Details: _____

PATIENT NAME: _____

MUSCULOSKELETAL:

Gout Yes No Details: _____
Arthritis Yes No Details: _____
Low back strain/pain/sciatica Yes No Details: _____
Pain in hips/knees/ankles/feet Yes No Details: _____
Assistance to ambulate Yes No Details: _____
Exercise limitation: (CIRCLE ONE) None / Minimal / Severe

CANCER

Breast Yes No Details: _____
Endometrial Yes No Details: _____
Uterine Yes No Details: _____
Prostrate Yes No Details: _____
Other: _____
Treatment: _____
Remission: _____

WEIGHT RELATED INJURIES AND TRAUMA

Yes No Details: _____

NEUROLOGICAL

Stroke Yes No Details: _____
Seizure Yes No Details: _____
Epilepsy Yes No Details: _____

PSYCHOLOGICAL DISORDERS

Depression Yes No Details: _____
Bi-Polar Yes No Details: _____
Anxiety Yes No Details: _____

EATING DISORDER

Yes No Details: _____

If Yes, have you been seen by a specialist? Yes No

Do you use any of the following medications?

Aspirin Yes No
Non-Steroidal Anti-Inflammatory Drug (NSAID) Yes No
Blood Thinner (Coumadin, Plavix, Lovenox) Yes No

PATIENT NAME: _____

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to measure sleep deprivation. This survey asks for your views about your health. Please carefully read the following questions and write in the most appropriate response.

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't 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:

0 = Would **never** doze

1 = **Slight** chance of dozing

2 = **Moderate** chance of dozing

3 = **High** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading.....	<input type="checkbox"/>
Watching TV.....	<input type="checkbox"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting).....	<input type="checkbox"/>
As a passenger in a car for an hour without a break.....	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit.....	<input type="checkbox"/>
Sitting and talking to someone.....	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol.....	<input type="checkbox"/>
In a car, while stopped for a few minutes in the traffic.....	<input type="checkbox"/>
Total	<input type="checkbox"/>

PATIENT NAME: _____

