SWEDISH

Swedish Weight Loss Services
Patient History Form

What program are you considering?

☐ Non-Surgical Weight Management ☐ Bariatric Surgery

First Name: _____ MI: ____ Last Name:_____

Date of Birth:_____ Phone:_____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other Ethnicity: _____

Employer: _____

Emergency Contact (Please Print)**:**

First Name: _____ Last Name: _____

Relationship To You: _____ Phone: _____

Primary Care Physician:

Physician Name: _____ Phone: _____

Clinic Name: _____ Fax: _____

FAMILY HISTORY		Family Member
☐ Yes ☐ No	Alcoholism	_____
☐ Yes ☐ No	Lung Disease / Asthma	_____
☐ Yes ☐ No	Bleeding Disorder	_____
☐ Yes ☐ No	Diabetes Mellitus	_____
☐ Yes ☐ No	Heart Disease	_____
☐ Yes ☐ No	High Blood Pressure	_____
☐ Yes ☐ No	Kidney Disease	_____
☐ Yes ☐ No	Liver Disease	_____
☐ Yes ☐ No	Malignant Hyperthermia	_____
☐ Yes ☐ No	Mental Illness	_____
☐ Yes ☐ No	Obesity	_____
☐ Yes ☐ No	Cancer	_____
☐ Yes ☐ No	Other: _____	_____

PATIENT MEDICAL HISTORY / REVIEW OF SYSTEMS

Constitutional

Fevers	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No
Hair Loss	☐ Yes	☐ No
History of MRSA	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Bladder / Kidney

Loss of Bladder Control	☐ Yes	☐ No
Kidney Insufficiency	☐ Yes	☐ No
Kidney Failure	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No

Blood

Anemia	☐ Yes	☐ No
Blood Clot in Leg	☐ Yes	☐ No
Blood Clot in Lung	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Clotting Disorder	☐ Yes	☐ No
HIV	☐ Yes	☐ No

Head / Neck

Vision Problems	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No
Swallowing Difficulty	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No
Joint / Back Pain: _____	☐ Yes	☐ No
Plantar Fasciitis	☐ Yes	☐ No
Nerve Injury	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No

Cardiovascular

Heart Attack	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Rheumatic Fever / Valve Damage	☐ Yes	☐ No
Rhythm Disturbance / Palpitations	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
High Cholesterol / Triglycerides	☐ Yes	☐ No

Skin

Rashes Under Skin Folds	☐ Yes	☐ No
Poor Wound Healing	☐ Yes	☐ No

Other (Please list all other medical problems):

_____

Gastrointestinal

Heartburn / Acid Reflux	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No
Cirrhosis / Hepatitis / Jaundice	☐ Yes	☐ No
Gallbladder Problems	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Oxygen Dependence	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Endocrine

Hypothyroid	☐ Yes	☐ No
Hyperthyroid	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Type (circle): One Two Gestational		
Pre-Diabetes	☐ Yes	☐ No
Gout	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Migraines/Headaches	☐ Yes	☐ No

Gynecological

Are you pregnant or suspect pregnancy?	☐ Yes	☐ No
Are you using birth control?	☐ Yes	☐ No
Type (circle): Oral IUD Implant Injection		
How many pregnancies have you had? _____		
How many live births have you had? _____		
Are you planning to have more children?	☐ Yes	☐ No
Do you have PCOS?	☐ Yes	☐ No
Are you post-menopausal?	☐ Yes	☐ No
Are you on hormone replacement meds?	☐ Yes	☐ No
Are you current on your pap smear?	☐ Yes	☐ No
Are you current on your breast exam?	☐ Yes	☐ No

SURGICAL HISTORY

Month / Year

☐ Yes ☐ No Heart Bypass / Valve Replacement _____

☐ Yes ☐ No Pacemaker _____

☐ Yes ☐ No Gallbladder ☐ Open ☐ Lap _____

☐ Yes ☐ No Appendectomy _____

☐ Yes ☐ No Hysterectomy ☐ Abdominal ☐ Vaginal _____

☐ Yes ☐ No Cesarean Section _____

☐ Yes ☐ No Tubal Ligation _____

☐ Yes ☐ No Hernia Repair _____
Location: _____

☐ Yes ☐ No Transplant _____
Type: _____

☐ Yes ☐ No Joint Replacement _____

☐ Yes ☐ No Knee Surgery _____

☐ Yes ☐ No Back Surgery _____

☐ Yes ☐ No Other: _____ _____

BARIATRIC / GASTRIC HISTORY

Month / Year

☐ Yes ☐ No Gastric Bypass (RNY) _____

☐ Yes ☐ No Vertical Sleeve Gastrectomy (VSG) _____

☐ Yes ☐ No Adjustable Gastric Band (LAGB) _____

☐ Yes ☐ No Duodenal Switch _____

☐ Yes ☐ No Vertical Banded Gastroplasty (VBG) _____

☐ Yes ☐ No Gastric Balloon _____

☐ Yes ☐ No PEG Tube Insertion _____

☐ Yes ☐ No Nissen Fundoplication _____

☐ Yes ☐ No Other Stomach Surgery / Procedure _____

MEDICATIONS / ALLERGIES

It is important that we know what medications you are currently taking. Please help us by providing accurate, detailed information. **This includes vitamins, minerals and herbal supplements as well as any over the counter (OTC) medications (e.g. Tylenol, ibuprofen).**

Please list all medication allergies:_____

_____

Medication	Dose	Frequency

SLEEP APNEA QUESTIONNAIRE

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No Date:_____ Where:_____

Last appointment with Sleep Medicine? _____ Do you have an Oral Appliance? ☐ Yes ☐ No

Do you have a CPAP/BiPAP machine? ☐ Yes ☐ No Do you use it nightly? ☐ Yes ☐ No

If you have <u>not</u> been diagnosed with Sleep Apnea, please answer the questions below:

☐ Yes ☐ No Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

☐ Yes ☐ No Do you often feel tired, fatigued or sleepy during the daytime?

☐ Yes ☐ No Has anyone ever observed you stop breathing during your sleep?

☐ Yes ☐ No Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No Is your BMI greater than 35kg/m^2?

☐ Yes ☐ No Are you over the age of 50 years old?

☐ Yes ☐ No Is your neck circumference greater than 16 inches?

BEHAVIORAL HEALTH

Anxiety ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Anorexia ☐ Yes ☐ No

Bulimia ☐ Yes ☐ No

Bipolar Disorder ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

History of cutting ☐ Yes ☐ No

History of / current alcoholism ☐ Yes ☐ No

History of / current drug addiction ☐ Yes ☐ No

Have you been in a drug/alcohol rehab? ☐ Yes ☐ No

Date: _____

Other psychiatric problems: _____

Previous suicide attempts ☐ Yes ☐ No

Have you ever been physically abused? ☐ Yes ☐ No Have you ever been sexually abused? ☐ Yes ☐ No

Do you see a psychiatrist / psychologist / counselor? ☐ Yes ☐ No

If Yes, provide name and contact number: _____

Have you ever been hospitalized in a psychiatric ward? ☐ Yes ☐ No

If Yes, dates and location: _____

Have you ever taken medications for psychiatric problems or depression? ☐ Yes ☐ No

If Yes, name / side effects / duration: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and mark your response in the column you feel is most accurate.	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Everyday**
Little interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling asleep, staying asleep, or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or overeating.				
Feeling badly about yourself, feeling that you are a failure, or that you have let yourself, family or others down.				
Trouble concentrating on things such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you are moving around a lot more than usual.				
Thinking that you would be better off dead or that you want to hurt yourself in some way.				
PHQ-9 © Copyright 1999 Pfizer				

Please rate the following on a scale of 1 to 5: (1 = Least Satisfied; 5 = Very Satisfied)

Relationship (Single / Partner / Married / Divorced): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Current job: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Overall satisfaction with self: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SOCIAL HISTORY

Current Tobacco Use ☐ Yes ☐ No
Previous Tobacco Use ☐ Yes ☐ No
Quit Date: _____
Do you Vape or Chew? ☐ Yes ☐ No
Do you consume Alcohol? ☐ Yes ☐ No
How much? _____
Has Alcohol intake ever been a concern for you or those around you? ☐ Yes ☐ No

Do you use Cannabis? ☐ Yes ☐ No
Do you use Street Drugs? ☐ Yes ☐ No
Substance: _____
Do you drink Caffeinated Beverages? ☐ Yes ☐ No
How much? _____
Do you drink Soda or Carbonated Drinks? ☐ Yes ☐ No
How much? _____

WEIGHT HISTORY: HABITS / WEIGHT LOSS ATTEMPTS / EXERCISE

From what age have you been overweight / obese? _____
Current Weight: _____lbs. Healthiest Weight: _____lbs.
Highest Adult Weight: _____lbs. Lowest Adult Weight: _____lbs.

Have you ever taken medications for weight loss? ☐ Yes ☐ No
If Yes, which medications? _____

Which diets have you attempted, either on your own or supervised?

☐ 30/10	☐ 20/20 Lifestyle	☐ Atkins
☐ Calorie Counting	☐ High Protein / Low Carb	☐ Jenny Craig
☐ Ketogenic	☐ Low Fat	☐ Nutrisystem
☐ OptiFast / MediFast	☐ Physician Supervised	☐ SlimFast
☐ South Beach	☐ Weight Watchers	☐ Whole30

Do you eat while: ☐ Watching TV ☐ Using Computer / Phone ☐ In Bed ☐ In Car
Do you wake up at night to eat after being asleep? ☐ Yes ☐ No
Which eating habits do you identify with?

☐ Scheduled Meals	☐ Not Set Schedule	☐ Overeating	☐ Eating When Bored
☐ Only When Hungry	☐ Skipping Meals	☐ Rapid Eating	☐ Eating as a Reward
☐ Cleaning Plate	☐ Grazing	☐ Large Portions	☐ Inability to Feel Full

How often in a week do you eat:
Fast Food: _____ At a Restaurant: _____
Takeout / Delivery: _____ Homemade Meals: _____
Junk Food: _____

Describe your pace of eating: ☐ Slow ☐ Average ☐ Fast

During the last 3 months have you had any episodes of excessive overeating?
(i.e. significantly more than what most people would eat in a similar period.) ☐ Yes ☐ No
If Yes, does excessive overeating cause you to be distressed? ☐ Yes ☐ No
Are there medications you feel contribute to your weight? ☐ Yes ☐ No
If Yes, please list: _____

Have you ever used any of the following to control your weight and did you get treatment?

□ Consuming large portions followed by vomiting Date: _____ Treatment: □ Yes □ No

□ Consuming large portions followed by restricting food Date: _____ Treatment: □ Yes □ No

□ Laxatives Date: _____ Treatment: □ Yes □ No

□ Diuretics Date: _____ Treatment: □ Yes □ No

□ Vomiting Date: _____ Treatment: □ Yes □ No

Do you have food allergies? □ Yes □ No Do you have food intolerances? □ Yes □ No

If Yes, list food and reaction: _____

_____

Describe your **current** activity level (please give examples of activity):

□ Restricted (wheelchair or bed bound)

□ Sedentary (e.g. desk job, light housecleaning)

□ Low Active (90 – 120 minutes each week) Example: _____

□ Active (121 – 150 minutes each week) Example: _____

□ Very Active (greater than 150 minutes per week) Example: _____

Why do you want to lose weight? _____

_____

_____

How do you think weight loss will impact your life? _____

_____

_____

What behaviors do you feel you will need to change? _____

_____

Do you have a Support Person that is encouraging of this journey? _____

What are your weight loss goals and expectations? (e.g. pounds to lose, time frame) _____

_____

What other goals would you like to set for yourself? _____

_____

Is there anything else you would like to share? _____

_____

Patient Signature: _____ Date: _____

By signing above, you agree that all information provided is accurate to the best of your knowledge