



THE CENTER FOR SURGICAL WEIGHT-MANAGEMENT

[www.StAlexiusNewStart.com](http://www.StAlexiusNewStart.com)

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# HEALTH HISTORY

DATE: \_\_\_\_\_

\_\_\_\_\_  
 LAST NAME FIRST NAME AGE HEIGHT WEIGHT  
\*Please use your legal name.

\_\_\_\_\_  
 OCCUPATION How long at current weight

EMPLOYMENT STATUS:  Full Time/Active Duty     Part Time     Self Employed     Home Maker  
                            Student     Retired     Disabled     Un-employed     Not Specified

\_\_\_\_\_  
 DATE OF BIRTH MARITAL STATUS:    M    S    W    D  
 RACE:             White     Black     Asian  
                            Hispanic     Native American     Other \_\_\_\_\_

The information you provide will help us plan your treatment.

**PRIMARY HEALTH CARE PROVIDER (Physician, Nurse Practitioner, etc.)**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

How long has she / he provided medical care for you? \_\_\_\_\_

**OTHER TREATING PHYSICIANS**

Name	Phone Number	Specialty (i.e. Cardiology, endocrinology)

**WHO IS THE PERSON TO NOTIFY IMMEDIATELY FOLLOWING SURGERY?**

NAME: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_

Phone: (check where to call)     Home \_\_\_\_\_     Work \_\_\_\_\_  
 Will she / he be waiting at the hospital during your surgery?     No     Yes

**MEDICATIONS TAKEN**

Name	Strength	Frequency		Purpose	When Started

**MEDICATIONS TAKEN (CONTINUED)**


Are you allergic to any medicine or foods?  No  Yes

Please list drug/food and reaction: \_\_\_\_\_  
 \_\_\_\_\_

**LIST ANY SURGERY** Please indicate with a \* if done laparoscopically.

Surgery	Date	Reason

Have you ever had surgery to aid in weight loss?  No  Yes

**FAMILY HISTORY**

			<input checked="" type="checkbox"/> Check all that apply.					
Family Member	Age now or at death	Cause of death	High Blood Pressure	Heart Problems	Diabetes	Stroke	Cancer	Obesity
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Sibling #1								
Sibling #2								
Sibling #3								

Name: \_\_\_\_\_

Please answer all of the following questions related to your current or past medical history.

<b>CARDIOVASCULAR SYSTEM :</b>		YES	NO		YES	NO
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>		Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Irregular or rapid heart rate	<input type="checkbox"/>	<input type="checkbox"/>		Leg Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>		Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>		Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>		Ankle edema (swelling of legs and feet)	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>				
Do you see a cardiologist?	<input type="checkbox"/>	<input type="checkbox"/>		Name:		
				Phone:		
Have you had: a stress test, cardiac catheterization, angioplasty or heart surgery)?	<input type="checkbox"/>	<input type="checkbox"/>		Circle all the procedures that apply. Indicate dates:		

<b>ENDOCRINE SYSTEM :</b>		YES	NO		YES	NO
Diabetes (Type I or Type II) <small>If yes: circle one</small>	<input type="checkbox"/>	<input type="checkbox"/>		Hypoglycemia (low blood sugars)	<input type="checkbox"/>	<input type="checkbox"/>
Gestational diabetes (with pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>		Hypothyroidism or thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Insulin resistance (elevated blood sugars)	<input type="checkbox"/>	<input type="checkbox"/>		Please send TSH level (thyroid test) drawn within last 6 months		

<b>RESPIRATORY SYSTEM :</b>		YES	NO		YES	NO
Shortness of breath with activity	<input type="checkbox"/>	<input type="checkbox"/>		Sleep apnea (stop breathing while you are sleeping)	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>		If yes, have you had a sleep study?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent awakening to catch breath	<input type="checkbox"/>	<input type="checkbox"/>		Do you use a C-PAP or BI-PAP machine (circle which one)?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of last attack:				Blood clots in lungs	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		If yes, do you have a vena cava filter?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, number of occurrences in last 2 years				Are you on blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or COPD	<input type="checkbox"/>	<input type="checkbox"/>				

<b>GASTROINTESTINAL SYSTEM :</b>		YES	NO		YES	NO
Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>		Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when and type of treatment				If yes, has your gallbladder been removed? Date _____	<input type="checkbox"/>	<input type="checkbox"/>
GERD or heartburn	<input type="checkbox"/>	<input type="checkbox"/>		Have you had x-rays that document gallstones?	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease (Crohn's or ulcerative colitis)	<input type="checkbox"/>	<input type="checkbox"/>		If yes, please send a copy of x-ray report.		
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>				

Name: \_\_\_\_\_

**MUSCULOSKELETAL SYSTEM :**

Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Have you had treatment by a chiropractor?	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative disc disease	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Do you take anti-inflammatory medications?	<input type="checkbox"/>	<input type="checkbox"/>
If, yes, circle sites affected (Neck, Hands, Back, Hips, Knees, Ankles, Feet)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list _____		
Have you had a joint replacement or back surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had physical therapy treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when			If yes, when		
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>			

**GENITOURINARY SYSTEM :**

(Females Only)

YES NO

YES NO

Urinary stress incontinence (loss of urine with coughing, sneezing, laughing)	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic ovarian syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Heavy menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Do you use birth control?	<input type="checkbox"/>	<input type="checkbox"/>
It is strongly recommended that female patients begin using birth control prior to surgery. Weight loss may improve fertility.					

**NEUROPSYCHOLOGICAL SYSTEM :**

YES NO

YES NO

Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
If yes, any paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	History of drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where?			If yes, how long have you been drug free?		
Transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	History of alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long have you been alcohol free?		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please circle (Bulimia Anorexia Nervosa Compulsive Overeating)		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	If yes, were you treated?	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when and where?		

## WEIGHT AND DIET HISTORY :

(Many insurance companies require physician documentation of weights and supervised weight loss attempts. In an effort to expedite the approval process, you may want to contact your primary care physician for that documentation to be sent to us.)

### LIFESTYLE:

	YES	NO		YES	NO
How many years have you been more than 75 pounds overweight?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a snacker?	<input type="checkbox"/>	<input type="checkbox"/>
What is your lowest weight since you were 18 years old?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , what are your favorite snacks?		
What is your highest weight since you were 18 years old?	<input type="checkbox"/>	<input type="checkbox"/>	Do you eat sweets?	<input type="checkbox"/>	<input type="checkbox"/>
How long have you been actively attempting to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , how often?		
What is the maximum amount of weight you have lost?	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
How did you accomplish that weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , how many drinks per week?		
How long were you able to maintain that weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use caffeine? (Coffee, colas, chocolate, energy drinks, pills such as No Doz or Jet Alert)	<input type="checkbox"/>	<input type="checkbox"/>
How many times per day do you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , what type?		
What are your favorite foods?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , how much per day?		

### OTHER:

	YES	NO		YES	NO
Do you have any hearing impairment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes</b> , what type?		
<b>If yes</b> , how many packs per day?			<b>If yes</b> , how many times per week?		
<b>If no</b> , did you ever smoke and when did you quit?			<b>If no</b> , what prevents you from exercising?		
PLEASE NOTE YOU WILL BE ASKED TO QUIT SMOKING PRIOR TO SURGERY TO DECREASE YOUR SURGICAL RISKS.			Do you require any aides for mobility - ie cane, walker, wheelchair (Please circle)	<input type="checkbox"/>	<input type="checkbox"/>
			Do you have any religious preferences that effect your healthcare?	<input type="checkbox"/>	<input type="checkbox"/>

Name: \_\_\_\_\_