# *DEACONESS WEIGHT LOSS SOLUTIONS*

## MEDICAL HISTORY FORM FOR INITIAL CONSULTATION

**(ALL PAPERWORK MUST BE COMPLETED TO BE CONSIDERED A CANDIDATE FOR OUR PROGRAM)**

**Name** _____ **Date of Birth** _____ **Age** _____

**Primary Physician** _____ **Physician's Phone #** _____

**Date and reason for most recent office visit** _____

**MEDICAL CONDITIONS -**

**PLEASE CHECK ONLY THOSE FOR WHICH YOU ARE BEING TREATED:**

| **Condition** | **Year Diagnosed** |
|---|---|
| ____Diabetes | _____ |
| ____High Blood Pressure | _____ |
| ____High Cholesterol | _____ |
| ____Heart Disease | _____ |
| ____Heart Attack | _____ |
| ____Sleep Apnea | _____ |
| ___CPap / BiPap | _____ |
| ____Asthma | _____ |
| ____Arthritis | _____ |
| ____Cancer | _____ |

(Indicate the type and location of cancer)

_____

| | |
|---|---|
| ____Acid Reflux / GERD | _____ |
| ____Depression/Anxiety/Bipolar disorder | |
| ____GI procedures | _____ |
| ____Back Pain | _____ |
| ____Joint Pain | _____ |
| ____Other: _____ | |

**Are you allergic to any medications? YES_____ NO_____**

| **MEDICATION ALLERGY:** | **REACTION TO MEDICINE:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**CURRENT MEDICATIONS**

**(include over-the-counter medicines & vitamins):**

| **Name of Drug** | **Dose / Frequency** | **Reason Taken** |
|---|---|---|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

On Oxygen? _____

**PLEASE ANSWER THE FOLLOWING QUESTIONS: Please Circle YES OR NO**

Do you have Crohn's Disease? **YES** **NO**

Do you have Colitis? **YES** **NO**

Are you currently using on Oxygen? **YES** **NO**

Are you currently on Dialysis? **YES** **NO**

Do you have a Single Kidney? **YES** **NO**

Are you currently on a Transplant List? **YES** **NO**

Are you Wheelchair Bound? **YES** **NO**

Are you able to walk without assistance? **YES** **NO**

Have you been diagnosed with Pulmonary Hypertension? **YES** **NO**

Are you over the Age of 65? **YES** **NO**

Are you under the Age of 21? **YES** **NO**

Have you used illegal drugs in the past year? **YES** **NO**

Are you currently being treated for Cancer? **YES** **NO**

Have you been treated for Cancer in the Past Year? **YES** **NO**

Have you attempted or been treated for Suicide in the Past Year? **YES** **NO**

Have you been hospitalized in a Psychiatric Hospital in the Past Year? **YES** **NO**

Have you been treated by a physician for Anorexia? **YES** **NO**

Have you been treated by a physician for Bulimia? **YES** **NO**

Have you been treated by a physician for Binge-Eating? **YES** **NO**

Have you been treated by a physician for Purging after meals? **YES** **NO**

Have you ever had Gastric Bypass Surgery? **YES** **NO**

Have you had Lap-Band Surgery? **YES** **NO**

Have you had Sleeve Gastrectomy Surgery? **YES** **NO**

Have you had Nissin Surgery? **YES** **NO**

Have you had Gastric Balloon Surgery? **YES** **NO**

Have you ever had Hernia Surgery? **YES** **NO**

Have you ever had Surgery Outside of the United States? **YES** **NO**

**YOUR SIGNATURE** _____ **DATE**_____

**ISTORY OF SURGERIES AND HOSPITALIZATIONS:**

| DATE | TYPE OF SURGERY OR HOSPITALIZATION | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**If you have been hospitalized in the last 6 months, please explain why: _____

_____

## SOCIAL HISTORY

Do you smoke? YES___ NO___ If YES, how many packs per day? _____ For how long? _____

How old were you when you started smoking? _____ Are you willing to quit? YES or NO

If NO, but you have smoked in the past, what year did you **stop** smoking? _____ Age started? _____

Do you use E-cigarettes/vapor? YES or NO Do you use nicotine in the form of patches, lozenges, or gum? YES or NO

Do you drink alcohol? Daily___ Weekly___ Rarely___ Never___ IF DAILY, how many drinks per day? _____

Did you drink heavily in the past? YES or NO If yes, do you still? Yes or No OR, When did you stop? _____

Are you currently using Illegal drugs? YES or NO Have you used illegal drugs in the past? YES or NO

*If YES, what drug(s), substances? _____

**.How much did you use? _____ When did you start using? _____

***When did you stop the above substances? _____

_____

**Please include any other important health information that is not covered elsewhere on this Medical History form:**

_____

**YOUR SIGNATURE** _____ **DATE**_____

# FAMILY HISTORY

## PLEASE CHECK (✓) ALL THAT APPLY AS THIS INFORMATION IS VERY IMPORTANT

**If you are unaware of your family history please document it here:** _____

| | ARTHRITIS | CANCER (please indicate the type of cancer and location, if pertinent) | DIABETES | HEART ATTACK | HEART DISEASE | HIGH BLOOD PRESSURE | LIVER DISEASE | LUNG DISEASE | OBESITY | SLEEP APNEA | STROKE | CURRENT AGE (if still living) | DEATH – indicate age and cause |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MOTHER** | | | | | | | | | | | | | |
| **FATHER** | | | | | | | | | | | | | |
| **MATERNAL GRANDMOTHER (mother's family)** | | | | | | | | | | | | | |
| **MATERNAL GRANDFATHER (mother's family)** | | | | | | | | | | | | | |
| **PATERNAL GRANDMOTHER (father's family)** | | | | | | | | | | | | | |
| **PATERNAL GRANDFATHER (father's family)** | | | | | | | | | | | | | |
| **YOUR SIBLINGS (please indicate for each diagnosis whether it is brother / sister who was affected)** | | | | | | | | | | | | | |

**YOUR SIGNATURE** _____ **DATE**_____