WILSON HEALTH
Weight & Wellness

Please complete and bring to your first appointment

WILSON HEALTH WEIGHT AND WELLNESS HEALTH HISTORY FORM

Name: _____ Date of Birth: _____

I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important that the physician have complete and accurate information in order to provide safe medical evaluation, recommendations, and care. I understand that this medical history is used in providing care through Wilson's Weight and Wellness Center and that some information may need to be shared with other providers or counselors.

_____ _____/_____/_____
signature date

Weight History: Age____ How many years have you been overweight?_____
Since: childhood____ puberty____ adulthood____ certain event _____

Lowest adult weight _____ Lowest weight in the past 5 years _____
Highest weight _____ Current weight _____ Height _____ BMI _____
Ideal body weight _____ Excess body weight_____

Attempted weight loss:

Programs tried: Weight Watchers Jenny Craig HMR Optifast Ideal Protein
Nutrisystems TOPS Slimfast Medifast
Other:_____
Weight loss on those programs: _____ Weight regain: _____
Number of attempts: _____

Medications tried: Topamax Metformin Contrave Saxenda Belviq Diurex
Fen-Phen Alli Redux Dexedrine Adipex Xenical
Meridia Qsymia other:_____
Over the counter medications/ supplements:_____
Best weight loss on medications:_____

Self Directed Diets: _____

Alternative methods of weight loss: _____

Where is most of your weight located: waistline hips arms/ legs face all
What has been your greatest single weight loss in the past? # pounds:_____
How?:_____
How long did you sustain the weight loss?_____
Have you had previous weight loss surgery? YES NO Explain:_____

Name_____

DOB_____

Please list physicians you see:

Primary care: _____

Cardiologist:_____

Pulmonologist:_____

Gynecologist or Urologist:_____

Orthopedic surgeon:_____

Endocrinologist: _____

Psychologist/ psychiatrist:_____

Other:_____

The office will be contacting you to review all of your health information to update your chart. Complete this so you are ready for their call:

Past Medical History:

Heart			**Lung**		**Liver**		
Angina	MI	CHF	COPD	emphysema	fatty liver	cirrhc	mono
HTN	arrythmia/ IRR HR		shortness of breath		Hepatitis		
high cholesterol		WPW	sleep apnea/OSA		other:		
Renal/ Kidney			**Cancer:**		**Musculoskeletal:**		
Kidney stones		insufficiency	type:_____		arthritis	neck back pain	
renal failure		proteinuria	treatment: chemo ra		fibromyalgia		
other:			Year treated:_____		other:		
Urologic:			**Endocrine**		**Neurological**		
impotence	sexual dysfunction		diabetes: type 1 type		seizure	syncc	stroke
UTI	incontinence		Average glucose:___		headaches	head injury	
other:			other:		other:		
GI:	irritable bowel		depression	bi-polar	**Hematology**		
hiatal hernia	GERD	Gastroparesis	anxiety	dementia	bleeding disorder		
constipation	diarrhea	dysphagia	Eating disorder	schizophrenia	clotting disorder		
nausea/ vomitting		ulcer			Factor V Leiden		
pancreatitis	gallstones				transfusion reaction		
Infectious disease			**Reproductive:**				
HIV	TB	MRSA	Polycystic ovaries		Please use a separate sheet as needed		
C. Diff	hepatitis	STD	impotence				
other:			Current pregnancy				

Previous Surgery (Please include approximate date and location):

_____

_____

_____

Name_____

DOB_____

The office will be contacting you to review all of your health information to update your chart. Complete this so you are ready for their call:

Medications:

name	dose	how often	purpose

Allergies:	reaction:	**Allergies:**	reaction:

Family History

check box	father	mother	brothers	sisters	Father's father	Father's mother	Mother's father	Mother's mother
asthma								
heart attacks								
cancer								
diabetes								
gallbladder disease								
HTN								
strokes								
weight problems								
arthritis								
seizures								
anesthetic problems								

Name_____

DOB_____

Social History

1. Do you currently smoke or use tobacco? YES NO If yes, how much?_____
   If past, when did you quit?_____ Number of years:_____
2. Do you eat sweets frequently? YES NO If yes, how much?_____
3. Do you drink alcohol? YES NO If yes, how much?_____
4. Do you/ have you ever used illegal drugs? YES NO Explain_____
   _____
5. Do you drink caffeinated beverages? YES NO If yes, how much?_____
6. Marital status:_____
7. Do you have children? YES NO If yes, list ages: _____
8. Do you wear any of the following? Dentures Hearing aid Glasses CPAP/BIPAP
9. Have you ever been hospitalized for psychiatric reasons? YES NO Explain_____
10. Do you exercise? YES NO If yes, how much?_____
11. Are there barriers that prevent you from exercising?_____
12. What is your occupation?_____
    Do you do heavy lifting? Explain:_____
13. Please list your hobbies and recreational activities:_____
    _____
14. Educational level:_____

Sleep Apnea Assessment

Sleep apnea is often associated with excess weight. Your physician will use this assessment as one of the tools to determine if a referral is necessary to the Wilson Sleep Center.

STOP BANG Questionnaire

☐ **I am treated for sleep apnea. If not, circle approapriate answer:**

1	**Snoring.**	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES NO
2	**Tired**	Do you often feel tired, fatigued, or sleepy during daytime?	YES NO
3	**Observed**	Has anyone observed you stop breathing during your sleep?	YES NO
4	**Blood Pressure**	Do you have or are you being treated for Hypertension?	YES NO
5	**BMI**	Is your BMI more than 35?	YES NO
6	**Age**	Age over 50 yr old?	YES NO
7	**Neck circumference**	Is your neck circumference greater than 40 cm?	YES NO
8	**Gender**	Are you male?	YES NO

*High risk of OSA: answering yes to three or more items **total YES *: _____**

Please rate your readiness to change:

1 2 3 4 5 6 7 8 9 10

not sure — thinking about it — need more information — Let's go!

Note any barriers to change: _____

_____

_____

Name_____

DOB_____

Wilson Weight and Wellness 24 hour diet recall

Please list all foods and quantities consumed in the last 24 hour period. Include everything taken in. Be as precise as possible listing portion size, how prepared (fried/baked…) and provide time of day.

breakfast

snack

lunch

snack

dinner

snack

Physical activity in the past 24 hours:

Physical activity weekly regimen:

Name_____

DOB_____

Personal Statement Please describe in your own words why you are asking to have weight loss surgery. Include how your weight has affected your health, your employment, your relationships, or your social life. Please use additional paper if needed.

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