Natividad WEIGHT LOSS
Inspiring healthy lives℠

1441 Constitution Boulevard, Salinas, CA 93906
(831) 783-2556 | www.natividad.com/weight-loss

New Patient Health Information

Please complete this form to provide information regarding your medical condition. All information will be kept confidential. Please bring the completed questionnaire to your consultation appointment.

Patient Name: _____

Address: _____

Date of Birth: _____

Preferred Phone: _____ ❑ Home ❑ Work ❑ Cell

Secondary Phone: _____ ❑ Home ❑ Work ❑ Cell

Primary Language: _____

Referring Physician and Clinic: _____

Other Physicians who Care for You: _____

Considering Weight Loss Surgery

How long have you been considering weight loss surgery? _____

Do you know other people that have had an operation for obesity? ❑ Yes ❑ No

Do you have family and friends supportive of your decision to undergo weight loss surgery? ❑ Yes ❑ No

What are your main reasons for considering an operation to help you lose weight? _____

Past Medical History

Please list all your current and past medical problems.

Diagnosis/Problem	When diagnosed	Name of treating doctor, or comment

Current Medications

Please tell us about medications you are currently taking.

Name of medication	Dosage	Doses per day

Allergies

Please tell us about your allergies and what reaction you have.

Medications	Reaction

Surgical History

Please list ALL surgeries you have had (including C-sections, and minor procedures).

Surgery	Year performed	Comment

Social History

Are you: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Who is currently living with you? (spouse/children/friend, etc.) _____

_____

What is your occupation?_____

Habits

Tobacco

Do you smoke? ❑ Yes ❑ No Packs per day _____ How many years? _____

Did you smoke? ❑ Yes ❑ No Packs per day_____ How many years? _____

When did you quit? _____

Alcohol

Do you drink alcohol? ❑ Yes ❑ No How many drinks per day/week_____

Are you a recovering alcoholic? ❑ Yes ❑ No When was your last drink? _____

Caffeine

Do you drink coffee, tea, soft drinks? ❑ Yes ❑ No

How many cups per day? _____ How many sodas per day? _____

Other Substances

Do you use, or have you ever used, any recreational drugs? ❑ Yes ❑ No

Are you in recovery? ❑ Yes ❑ No How long ago did you last use? _____

To ensure your safety in surgery, please check all that you have used in the last year:

❑ Marijuana ❑ Heroin ❑ Methamphetamine ❑ Crack ❑ Cocaine ❑ Uppers ❑ Downers

Family History

Please list medical problems in your immediate family:

Mother _____

_____

Father_____

_____

Brothers and Sisters _____

_____

Weight History

Are your parents overweight? ❑ Mother ❑ Father

Are your siblings overweight? ❑ Sister(s) ❑ Brother(s)

Any other relatives who are severely overweight? _____

Your obesity started: ❑ In Childhood ❑ In Puberty ❑ In Adulthood ❑ After Pregnancy ❑ After a Traumatic Event ❑ Other

Your weight as an adult has ranged between _____pounds, and _____pounds.

Your most stable adult weight has been _____ pounds at age _____ .

Your height: _____

Your current weight: _____ pounds. My realistic goal weight is _____ pounds.

I felt best at a weight of _____ pounds when I was_____ years of age.

Eating Patterns

Check all that apply.

How would you describe your portion size: ❑ Small ❑ Medium ❑ Large

Type of food you eat: ❑ Normal ❑ Healthy ❑ Fast Food ❑ Junk Food

Taste preference: ❑ Sweets ❑ Salty ❑ Comfort Foods ❑ Other _____

Number of meals you eat each day: _____ Number of snacks per day:_____

You eat extra calories due to: ❑ Stress ❑ Boredom ❑ Sweets craving ❑ Snacking ❑ "Closet Eating" ❑ Binging

Diet History

Have you participated in any of the following weight loss programs? *Check all that apply.*

❑ Conventional "self" dieting (limiting calorie intake)
❑ Medifast
❑ Meridia
❑ Redux
❑ Phen-fen
❑ Schick Center

❑ Nutra-System
❑ Weight Watchers
❑ Jenny Craig
❑ Slim Fast
❑ Diet Center
❑ Metabolife
❑ Optifast

❑ Atkins Diet
❑ Lindora
❑ Diet Pills
❑ Cambridge
❑ Sansum Wellness
❑ Xenical
❑ Jaw Wiring

❑ Hypnosis
❑ Acupuncture
❑ Protein Diet
❑ Medically Supervised Weight Loss Clinics
❑ Overeaters Anonymous
❑ Other_____

Weight Loss History – this form will go to your insurance company

Please be as complete as possible.

Date *List in order of most recent first*	**Weight Loss Attempt** *What kind? Supervised? By whom? Medicine?*	**Beginning Weight**	**Amount of Weight Lost**	**Over How Many Months?**	**Weight Gained Back?**	**Over How Long?**
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	

Diet history is very important to gaining insurance approval and/or qualifying for surgery.

We know that you cannot remember every diet you have ever been on. Please be as complete as possible.

Review of Systems

Please check Yes or No to each of the following diseases, symptoms, or conditions.

General

Have you ever had:

❑ Yes ❑ No Problems with anesthesia

❑ Yes ❑ No Significant weight loss, not associated with dieting. How much in past year?_____

❑ Yes ❑ No Significant weight gain. How much in past year?_____

❑ Yes ❑ No Night sweats

❑ Yes ❑ No Fever

❑ Yes ❑ No Chills

Endocrine

Have you ever had:

❑ Yes ❑ No Thyroid problems (over or under active)

❑ Yes ❑ No Diabetes

Treated with: ❑ diet and exercise ❑ pills ❑ insulin shots

❑ Yes ❑ No Hormone replacement therapy

Cardiovascular

Have you ever had:

❑ Yes ❑ No Chest pain (angina)

❑ Yes ❑ No Heart attack

❑ Yes ❑ No High blood pressure

Treated with: ❑ not treated ❑ medication(s) ❑ other

How many medications do you take for your blood pressure?_____

❑ Yes ❑ No Heart murmur

❑ Yes ❑ No Pacemaker

❑ Yes ❑ No Palpitations

❑ Yes ❑ No History of abnormal EKG or heart study

❑ Yes ❑ No Congestive heart failure (CHF)

❑ Yes ❑ No Foot or ankle swelling

❑ Yes ❑ No Disease of any blood vessels (arteries or veins)

❑ Yes ❑ No Blood clots in legs or lungs

Respiratory

Have you ever had:

❑ Yes ❑ No Difficulty breathing / shortness of breath

❑ Yes ❑ No Snoring

❑ Yes ❑ No Observed pauses in breathing during sleep

❑ Yes ❑ No Feeling of smothering when you lie down or are awakened from sleep

❑ Yes ❑ No Pneumonia

❑ Yes ❑ No Bronchitis
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Cough
❑ Yes ❑ No Wheezing
❑ Yes ❑ No Lung cancer
❑ Yes ❑ No Asthma
❑ Yes ❑ No Coughing up blood
❑ Yes ❑ No Other lung disease: _____

Gastrointestinal (GI)

Have you ever had:

❑ Yes ❑ No Heartburn
❑ Yes ❑ No Stomach ulcers
❑ Yes ❑ No Nausea or vomiting
❑ Yes ❑ No Vomiting blood
❑ Yes ❑ No Diarrhea or constipation
❑ Yes ❑ No Blood in stool
❑ Yes ❑ No Inflammation of the pancreas
❑ Yes ❑ No Hep-C or liver problems
❑ Yes ❑ No Jaundice (yellow skin or eyes)
❑ Yes ❑ No Cirrhosis or tifagy liverti
❑ Yes ❑ No Spleen disease (easy bleeding)
❑ Yes ❑ No Abdominal problems, stomach pain
❑ Yes ❑ No Disease of the small or large intestine
❑ Yes ❑ No Colon polyps or cancer
❑ Yes ❑ No Hemorrhoids

Psychiatric / Mood

Have you ever had:

❑ Yes ❑ No Mood changes or mood difficulties
❑ Yes ❑ No Depression, suicidal thoughts or actions
❑ Yes ❑ No Anxiety
❑ Yes ❑ No Bipolar disorder
❑ Yes ❑ No Schizophrenia
❑ Yes ❑ No Anorexia
❑ Yes ❑ No Bulimia (binge and purge eating)
❑ Yes ❑ No Other psychiatric or mood disorders:_____

Thank you for completing this questionnaire. Please bring it with you to your consultation visit with Dr. Di Stante.