



*Patient Demographic Information:*

Date \_\_\_\_\_

\_\_\_\_\_  
 (Title) First Name MI Last Name Maiden Name Suffix

What do you prefer to be called? \_\_\_\_\_

Street Address (including apartment number) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender .....  Male  Female

Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

*Emergency Contact Information:*

Who could we contact in case of an emergency? \_\_\_\_\_ Relationship \_\_\_\_\_

1st Phone Number \_\_\_\_\_  Home  Work  Other \_\_\_\_\_

2nd Phone Number \_\_\_\_\_  Home  Work  Other \_\_\_\_\_

Second Person to Contact \_\_\_\_\_ Relationship \_\_\_\_\_

1st Phone Number \_\_\_\_\_  Home  Work  Other \_\_\_\_\_

2nd Phone Number \_\_\_\_\_  Home  Work  Other \_\_\_\_\_

*Insurance Information:*

Name of Your Primary Medical Insurance Carrier \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Name of the Insured \_\_\_\_\_

Relationship to Insured .....  Self  Spouse  Child  Other

Address \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

Name of Your Secondary Medical Insurance Carrier \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Agreement Number \_\_\_\_\_ Name of the Insured \_\_\_\_\_

Relationship to Insured .....  Self  Spouse  Child  Other

Address \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

Patient's Name: \_\_\_\_\_

*Patient's Physician Information: (First and Last Name)*

Name of Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Please list any other physicians you see:**

Name of Physician \_\_\_\_\_ Speciality \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Name of Physician \_\_\_\_\_ Speciality \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Name of Physician \_\_\_\_\_ Speciality \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

*Pharmacy Information:*

Please provide the following information on the pharmacy you frequent the most.

Name of Pharmacy \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

*Weight/Diet History:*

1. What is your current height? ..... Feet \_\_\_\_\_ Inches

2. What is your current weight? ..... Pounds

3. What was your approximate weight in pounds at age...

(Only fill out boxes corresponding to ages that you have reached.)

10    lbs. 18    lbs. 25    lbs. 30    lbs.

35    lbs. 40    lbs. 45    lbs. 50    lbs.

60 and over    lbs.

4. What is the most you have ever weighed, not counting pregnancies? ..... lbs.

5. How is your weight distribution.

- Buttocks, thighs primarily
- Around your middle (abdominal area)
- Both of the above

Patient's Name: \_\_\_\_\_

*Weight Loss Diets*

Complete the table below, listing all food or liquid diets you have tried in an attempt to lose weight. This information is very important for you to complete in its entirety, so that you may be eligible for insurance coverage for your surgery.

Provided below is only a sample list of some diets. (Reminder: List all of the diets you previously tried.) If you haven't been on a physician-supervised diet, we encourage you to participate in a weight management program, starting as soon as possible.

- |                   |                   |                     |               |                 |
|-------------------|-------------------|---------------------|---------------|-----------------|
| Atkins Diet       | Fit American      | LA Weight Loss      | Mayo Clinic   | Richard Simons  |
| Cabbage Soup Diet | Grapefruit        | Liquid Protein Diet | Metabolite    | Slim Fast       |
| Calorie Count     | Herbal Life Diet  | Low Calorie         | Metrical      | Stillman        |
| Cambridge         | High Protein Diet | Low Carbohydrate    | Nutri-Systems | TOPS            |
| Dean Ornish       | Jenny Craig       | Low Fat             | Optifast      | Weight Watchers |

I have not been on any diets in order to lose weight.

Name of Diet	Year	How long were you on the diet? (months)	Number of Pounds Lost	Was this under a doctor's supervision?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

I have worked with a registered dietitian on a weight loss program. ....  Yes  No

Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

*Weight Loss Medications*

Complete the table below, listing all medications that you have taken in order to lose weight. This information is **very important** for you to complete in its entirety, so that you may be eligible for insurance coverage for your surgery.

Provided below are only samples of some medications that you may have tried. (Remember: List **all** of the medications you previously tried.)

Acutrim                      Bontril                      Didrex                      Iomamin                      Phentermine                      Xenical  
 Adipex                      Dexatrim                      Fen/Phen                      Meridia                      Redux

I have not been on any medications in order to lose weight.

Medication / Dose	Year	Length of Medications (months)	Number of Pounds Lost	Was this under a doctor's supervision?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

*Weight Loss Treatments*

Complete the table below, listing any behavioral treatments that you have tried in an attempt to lose weight. This information is **very important** for you to complete in its entirety, so that you may be eligible for insurance coverage for your surgery. Provided below are only some samples, provide us with **all** of the behavioral treatments you have attempted.

I have not tried any behavioral treatments to lose weight.

Counseling (Eating Disorder Center)                      Hypnosis                      Inpatient Therapy  
 Covenant Medical Center's Choices Eating Disorders Program

Behavioral/Combine Treatment	Year	Length of Program (months)	Number of Pounds Lost	Was this under a doctor's supervision?
1.				
2.				
3.				
4.				
5.				

Patient's Name: \_\_\_\_\_

*Allergy Information:*

1. Do you have allergies to any medications / substances? .....  Yes  No
- a. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- b. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- c. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- d. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- e. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
2. Do you have any environmental / food / latex allergies .....  Yes  No
- a. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- b. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- c. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- d. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_
- e. If yes, list \_\_\_\_\_ Reaction \_\_\_\_\_

*Medication Information:*

**List any prescription or over-the-counter medication and natural/herbal/vitamin supplements you are currently using. Please copy the name straight from the bottle.**

Medications	Dose	Times per Day	Years Started on Medication	Purpose
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

Please check here if you take more than 14 medications and then turn this page over and continue to list the rest of your medications.

Patient's Name: \_\_\_\_\_

Previous Surgery Information:

**Part I. Please list any surgical procedure you have had, the reason and the year. If relevant, please specify if the surgery was performed laparoscopically or open.**

I have had no surgical procedure in the past.

		Laparoscopic	Open	Year
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____
Type of Surgery _____	Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	____

Have you, or a blood relative, ever had any trouble with anesthesia? .....  Yes  No

If yes, please explain what occurred. \_\_\_\_\_

**Part II.**

Have you or one of your relatives/spouse ever had bariatric (weight reduction) surgery? .....  Yes  No

List each relative separate:

1a. What relationship is he/she to you?

Self  Mother  Father  Spouse  Brother  Sister  Other \_\_\_\_\_

b. What type of procedure was performed? .....  Gastric Banding  Roux-en Y Gastric Bypass

Distal Bypass  Don't Know  Other \_\_\_\_\_

c. Who performed the surgery? \_\_\_\_\_ Location \_\_\_\_\_  
Name of relative \_\_\_\_\_

2a. What relationship is he/she to you?

Self  Mother  Father  Spouse  Brother  Sister  Other \_\_\_\_\_

b. What type of procedure was performed? .....  Gastric Banding  Roux-en Y Gastric Bypass

Distal Bypass  Don't Know  Other \_\_\_\_\_

c. Who performed the surgery? \_\_\_\_\_ Location \_\_\_\_\_  
Name of relative \_\_\_\_\_

Patient's Name: \_\_\_\_\_

*Medical Health Information:*

Has a doctor or other health care provider told you that you have any of the following conditions? Please indicate by marking an X in the appropriate box. Specify the year diagnosed and the physician who currently manages the problem.

*Cardiac: (Heart)*

Coronary Artery Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Heart Attack  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, treatment \_\_\_\_\_

Elevated Cholesterol  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Elevated Triglycerides  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Congestive Heart Failure  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Valvular Heart Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

(e.g. Mitral Valve Prolapse, Mitral Valve Regurgitation, etc.)

Rheumatic Fever  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Heart Murmur  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Heart Arrhythmia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

(e.g. Irregular Heart Beat)

If yes, describe condition \_\_\_\_\_

Hypertension  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

(High Blood Pressure)

Heart Block  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Other Heart Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, describe condition \_\_\_\_\_

Have you experienced chest pain in the past year? .....  Yes  No

If yes, have you received treatment? .....  Yes  No

If yes, explain \_\_\_\_\_

Have you had any type of cardiac stress test? .....  Yes  No

Type \_\_\_\_\_ by Dr. \_\_\_\_\_ Year \_\_\_\_\_

Type \_\_\_\_\_ by Dr. \_\_\_\_\_ Year \_\_\_\_\_

*Pulmonary: (Lung)*

Have you ever required oxygen?  Yes  No Explain \_\_\_\_\_

Are you currently on oxygen?  Yes  No Amount \_\_\_\_\_ Reason \_\_\_\_\_

Asthma  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Pneumonia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Chronic Bronchitis  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

COPD (Emphysema)  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Tuberculosis  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Diagnosed Sleep Apnea  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, treatment \_\_\_\_\_

If on CPAP / BiPAP, what are the settings \_\_\_\_\_

*Endocrine:*

Diabetes Mellitus  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

(Sugar Diabetes) If yes, do you currently treat with insulin? .....  Yes  No

If yes to the above question and **you are a male:**

Erectile Dysfunction  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, treatment \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**If you are a female:**

Polycystic Ovarian Disease (PCOS)  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, treatment \_\_\_\_\_

Neuropathy  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, do you have any numbness/tingling/pain in your hands, legs and/or feet? .....  Yes  No

Retinopathy  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Have you been treated for any diabetic changes in your eyes? .....  Yes  No  
If yes, explain \_\_\_\_\_

Nephropathy  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Have you had any kidney problems related to your diabetes? .....  Yes  No  
Hyperthyroid  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Hypothyroid  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Adrenal (Cushings)  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Other \_\_\_\_\_  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

*Gastrointestinal:*

Reflux Disease (Heartburn)  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Hiatal Hernia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, describe condition \_\_\_\_\_  
Peptic Ulcer Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Gallbladder Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Hepatitis  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, Type  A  B  C  Uncertain of Type Treatment \_\_\_\_\_  
Other Liver Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, describe condition \_\_\_\_\_  
Irritable Bowel Disease  Yes  No  
Inflammatory Bowel Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
(Crohn's Disease, Ulcerative Colitis) If yes, describe condition \_\_\_\_\_  
Other \_\_\_\_\_  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

*Vascular Disease:*

Arterial Vascular Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Pulmonary Embolism  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Deep Vein Thrombosis  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Superficial Phlebitis  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Peripheral Edema  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
(swelling legs, ankles) If yes, do you currently treat with diuretics (water pills)? .....  Yes  No  
Leg Ulcers  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, do you currently have ulcers? .....  Yes  No  
Varicose Veins  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Patient's Name: \_\_\_\_\_

*Renal:*

Kidney Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, treatment \_\_\_\_\_

Urinary Stress Incontinence  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, treatment \_\_\_\_\_

Kidney Stones  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

*Central Nervous System:*

Seizure Disorders  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

CVA (Stroke)  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Migraine Headaches  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Other \_\_\_\_\_  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

*Orthopedic:*

Chronic Lower Back Pain  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Chronic Neck Pain  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, treatment \_\_\_\_\_

Diagnosed Osteoarthritis/  
Degenerative Joint Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, joints involved  Neck  Shoulders  Back  Hips  Hands/Wrists  
 Knees  Ankles  Feet  Heels

Do you have painful joints (without osteoarthritis/DJD)? .....  Yes  No

If yes, which joints?  Neck  Shoulders  Back  Hips  Hands/Wrists  
 Knees  Ankles  Feet  Heels

Autoimmune Disease  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
(e.g. Lupus, Rheumatoid Arthritis, Connective Tissue, etc.)  
Explain Further: \_\_\_\_\_

Gout  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, list joint involved \_\_\_\_\_

Fibromyalgia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Have you ever had any broken bones of the face? .....  Yes  No Describe: \_\_\_\_\_

Have you ever had broken bones of the back/neck? .....  Yes  No Describe: \_\_\_\_\_

*Blood Disorders:*

Anemia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, type, if known \_\_\_\_\_

Do you have, or have you had, any abnormalities with bleeding or clotting? .....  Yes  No  
If yes, explain \_\_\_\_\_

*Emotional Disorders:*

Depression  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Bipolar Affective Disorder  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Anxiety  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Schizophrenia  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Eating Disorders  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, what type \_\_\_\_\_

Other \_\_\_\_\_  Yes  No Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Patient's Name: \_\_\_\_\_

If you answered yes to any of the above questions for emotional disorders, please answer the two questions below.

1. Are you currently receiving any therapy or medications for the above conditions? .....  Yes  No
2. Have you ever been hospitalized for the above conditions? .....  Yes  No If yes, Year \_\_\_\_\_

*Other Medical Disorders or Symptoms That Concern You:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Cancer:*  Yes  No

1. Type/Organ(s) Affected: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_
2. Type/Organ(s) Affected: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_
3. Type/Organ(s) Affected: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

*Woman's Health History:* This section is for women only. **Men go to page 11** (Skin Problems)

1. Have you ever had a hysterectomy? .....  Yes  No  
If yes, please indicate .....  Vaginal  Abdominal  
If yes, please indicate year ..... \_\_\_\_\_  
If yes, were the ovaries removed? .....  Yes  No  
If yes, please indicate which ovaries. ....  Right  Left  Both  Don't Know
2. Have you ever had a Cesarean section? .....  Yes  No  
If yes, please indicate how many. .... \_\_\_\_\_  
If yes, please indicate year(s). .... \_\_\_\_\_
3. Have you ever had a tubal ligation? .....  Yes  No  
If yes, please indicate how the procedure was performed. ....  Open  Laparoscopic  
If yes, please indicate year. .... \_\_\_\_\_
4. Do you have a history of breast cancer? .....  Yes  No
5. Is there a chance you may currently be pregnant? .....  Yes  No
6. Have you ever been pregnant? .....  Yes  No **If no, skip to question 10.**
7. How many children do you have? ..... \_\_\_\_\_
8. Have you had any miscarriages? .....  Yes  No **If no, skip to question 10.**
  - a. If yes, how many miscarriages? ..... \_\_\_\_\_
  - b. At what point in the pregnancy did they occur? \_\_\_\_\_ weeks \_\_\_\_\_ weeks \_\_\_\_\_ weeks

Patient's Name: \_\_\_\_\_

9. Have you had an abortion? .....  Yes  No **If no, skip to question 10.**  
a. If yes, how many abortions? ..... \_\_\_\_\_  
b. At what point in the pregnancy did they occur? \_\_\_\_\_ weeks \_\_\_\_\_ weeks \_\_\_\_\_ weeks
10. Have you had any evaluation for infertility? .....  Yes  No **If no, skip to question 11.**  
If yes, what did the evaluation or treatment include? \_\_\_\_\_
11. Have you ever utilized any fertility enhancing treatment or evaluation? .....  Yes  No  
If yes, what did the evaluation or treatment include? \_\_\_\_\_
12. If you have not delivered any children, have you tried to conceive children? .....  Yes  No
13. Please indicate whether you are:  Pre Menopausal  Peri Menopausal  Post Menopausal  Don't Know
14. Do you currently menstruate? .....  Yes  No  
If no, what year did you stop menstruating? ..... \_\_\_\_\_
- If yes, please answer the following questions:**
- a. How many periods have you had during the last 12 months? \_\_\_\_\_
- b. Do you have regular periods? (When not on birth control pills, if on them presently) .....  Yes  No  
If yes, how often do you have your period? ..... every \_\_\_\_\_ days
15. Have you ever had a gynecological examination? .....  Yes  No
16. When was your last gynecological examination? ..... \_\_\_\_\_  
a. Who performed your gynecological examination? \_\_\_\_\_ Phone Number \_\_\_\_\_  
b. Did you have a Pap test? .....  Yes  No  
c. Have you ever had an abnormal Pap test? .....  Yes  No  
If yes, please explain \_\_\_\_\_  
d. Was a follow-up Pap test performed? .....  Yes  No Results \_\_\_\_\_
17. When was your last mammography examination? \_\_\_\_\_  
a. Have you ever had an abnormal mammography examination? .....  Yes  No  
b. If yes, please explain ..... \_\_\_\_\_  
c. What follow-up was performed? \_\_\_\_\_

### *Polycystic Ovary Disease Screening*

#### *Menstrual Irregularities:*

When not on birth control pills, do you have or have you ever had any of the following problems: (Not counting times that you were pregnant or nursing.)

1. Eight or fewer periods per year? .....  Yes  No
2. No periods for an extended period of time (4 or more months). .....  Yes  No
3. Irregular bleeding that starts and stops intermittently. ....  Yes  No
4. Do you have any fertility problems? .....  Yes  No  
If yes, have you seen a fertility specialist or been treated with fertility drugs to induce ovulation? .....  Yes  No

Patient's Name: \_\_\_\_\_

*Skin Problems:*

**Have you ever had, or do you currently have, any of the following problems?**

1. Adult acne, or severe adolescent acne. ....  Yes  No
2. Excess facial or body hair, especially upper lip, chin, neck, chest and/or abdomen. ....  Yes  No
3. Skin tags. ....  Yes  No
4. Balding or thinning hair. ....  Yes  No
5. Dark or discolored patches of skin on your neck, groin, under arms or in skin folds. ....  Yes  No

How did you hear about Covenant Clinic's Minimally Invasive Weight Loss Center?

- |                                                     |                                                   |                                                   |
|-----------------------------------------------------|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Primary Care Physician     | <input type="checkbox"/> Weight Management Center | <input type="checkbox"/> Friend/Family _____      |
| <input type="checkbox"/> Internet                   | <input type="checkbox"/> Television Special       | <input type="checkbox"/> Television Advertisement |
| <input type="checkbox"/> Magazine/Newspaper Article |                                                   |                                                   |
| <input type="checkbox"/> Other Physician _____      | Specialty _____                                   |                                                   |
| <input type="checkbox"/> Other _____                |                                                   |                                                   |

Patient's Name: \_\_\_\_\_

### The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not experienced some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the *most appropriate number* for each situation:

- 0 = Would Never Doze
- 1 = Slight Chance of Dozing
- 2 = Moderate Chance of Dozing
- 3 = High Chance of Dozing

Situation	Chance of Dozing
1. Sitting and Reading .....	<input type="text"/>
2. Watching TV .....	<input type="text"/>
3. Sitting, inactive in a public place (e.g. theater or a meeting) .....	<input type="text"/>
4. As a passenger in a car for an hour without a break .....	<input type="text"/>
5. Lying down to rest in the afternoon when circumstances permit .....	<input type="text"/>
6. Sitting and talking to someone .....	<input type="text"/>
7. Sitting quietly after lunch without alcohol .....	<input type="text"/>
8. In a car, while stopped for a few minutes in the traffic .....	<input type="text"/>
For Office Use Only	<input type="text"/>
9. Are you currently using CPAP or BiPAP? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No Settings _____

Please indicate if any of the following conditions have ever been a significant problem for you by marking an X in the appropriate box.

Observed Sleep Apnea (stop breathing while sleeping) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loud Snoring .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gasping for Breath at Night .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Waking Up with Headaches (regularly) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family History of Sleep Apnea .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Which Family Member? (please check all that apply)

- |                                 |                                               |                                               |                                   |
|---------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Father | <input type="checkbox"/> Maternal Grandmother | <input type="checkbox"/> Maternal Grandfather | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Paternal Grandmother | <input type="checkbox"/> Paternal Grandfather |                                   |

Patient's Name: \_\_\_\_\_

*Smoking / Drug / Alcohol / Caffeine History:*

1. Do you drink any beverages that contain caffeine on a regular basis? .....  Yes  No

**If no, skip to question 2.**

a. If yes, on average, how many caffeinated drinks do you drink per day?

Coffee	Regular Soda	Diet Soda	Tea	Hot Cocoa	Chocolate Milk	
6 oz.	12 oz.	12 oz.	6 oz.	6 oz.	8 oz.	Other

2. Do you currently use tobacco? .....  Yes  No

3. Have you ever used tobacco? .....  Yes  No

	Cigarettes Pack(s)	Cigars	Pipe	Chew/Snuff
a. Check the type(s) of tobacco you use.				
b. Age when you started tobacco use.				
c. Years of fairly regular tobacco use.				
d. Amount smoked/chewed per day.				

e. What kind of cigarettes did you smoke? .....  Filtered  Unfiltered

4. Do you currently drink alcohol? .....  Yes  No

**If no, skip to question 5.**

	Wine 4 oz.	Beer 12 oz.	Liquor 1 oz.	Mixed Drink 1 oz.	Other
a. Check the type(s) of alcohol you drink.					
b. Avg. number of drinks per week.					

5. Have you ever had a problem with alcohol in the past? .....  Yes  No

**If no, skip to question 6.**

a. Please indicate what year and for how long. Year \_\_\_\_\_ How Long \_\_\_\_\_

b. Have you ever received treatment? .....  Yes  No If yes, when? \_\_\_\_\_

6. Have you ever used any illicit drugs on a regular basis? (e.g. Marijuana, Cocaine, Heroin, Amphetamines, etc.) .....  Yes  No

**If no, skip to Family History.**

a. If yes, please indicate drug \_\_\_\_\_ How long ago? ...  < 6 months  6 months-1 year  > 1 year

b. If yes, please indicate drug \_\_\_\_\_ How long ago? ...  < 6 months  6 months-1 year  > 1 year

c. Have you ever received treatment? .....  Yes  No If yes, when? \_\_\_\_\_ how long? \_\_\_\_\_

d. Are you currently using drugs? .....  Yes  No If yes, please indicate drug(s) \_\_\_\_\_

Patient's Name: \_\_\_\_\_

*Family History:*

1. Are you a part of a multiple birth (twin, triplet, etc.)? .....  Yes  No  Don't Know  
 a. If yes, how many other infants were born with you? \_\_\_\_\_  
 b. Of those born with you, how many were identical to you? \_\_\_\_\_

In this section, complete this chart to the best of your knowledge. If you are adopted and/or have no knowledge of your biological family history, place an X below.

- I have no knowledge of my biological family history.  
 Adopted

Family Member	Approximate Weight (lbs.)	Present Age	If Deceased Age at Death	If Deceased, List Cause of Death	List Any Medical Problems e.g. Heart Disease, Cancer Diabetes, Hypertension
1. Mother					
2. Father					
3. Maternal Grandmother					
4. Maternal Grandfather					
5. Paternal Grandmother					
6. Paternal Grandfather					
7. Brother(s)					
8. Sister(s)					
9. Half Brother					
10. Half Sister					

Patient's Name: \_\_\_\_\_

*Social History:*

1. Which of the following best describes your current work status? (check only one)  
 Full Time    Part Time    Retired    Temporary    Unemployed    Sick Leave    Other \_\_\_\_\_  
 Disability (i.e., SSI, Medicare, Medicaid) \_\_\_\_\_ Date Began Disability \_\_\_\_\_  
Please indicate cause of disability \_\_\_\_\_
  - a. If employed, what is your occupation? \_\_\_\_\_
  - b. If employed, which of the following best represents your occupation? (check only one)  
 Office/Professional    Technician    Sales  
 Office/Clerical    Skilled/Craftsman    Unskilled/Semi-Skilled
2. What is your current marital status?  
 Never Married    Married    Separated  
 Divorced    Widowed    Living in a Marriage-Like Relationship
3. Which of the following best describes you? (check only one)  
 African-American/Black    White/Caucasian    Hispanic or Latino  
 Asian/Pacific Islander, specify \_\_\_\_\_  
 American Indian/Native American/Alaskan Native    Other \_\_\_\_\_
4. What category best describes your highest grade or year of school completed? (check only one)  
 Grade School    Some High School    High School Graduate  
 Vocational/Technical Training    Some College, No Degree    Associate Degree (2 years)  
 Bachelor's Degree    Master's Degree    Doctoral Degree  
 Other Advanced Degree (specify: \_\_\_\_\_ )
5. Do you have a religious affiliation? .....  Yes    No  
If yes, please specify:  Catholic    Jehovah Witness    Jewish    Protestant    Other \_\_\_\_\_

*Eating Patterns / Habits:*

1. Counting all meals and any snacks you may have, how many times a day do you usually eat? ..... \_\_\_\_\_ times
2. How many days a week do you eat out at  

<u>Breakfast</u>	<u>Brunch / Lunch</u>	<u>Dinner</u>
_____ days/week	_____ days/week	_____ days/week
3. In the past 6 months, have you experienced any food cravings (i.e., intense desires to eat specific food)? .....  Yes    No
4. During the past 6 months, did you ever eat what most people, like your friends, would think was a very large amount of food? .....  Yes    No
5. Did you ever eat a very large amount of food within a short time (2 hours or less)? .....  Yes    No

Patient's Name: \_\_\_\_\_

6. When you ate a very large amount of food, did you ever feel that you could not stop eating? Did you feel that you could not control what or how much you were eating?.  Yes  No
7. During the past 6 months, how often did you eat a very large amount of food with the feeling that your eating was out of control? .....

There may have been some weeks when you did not eat this way at all. And some weeks you may have eaten like this a lot. But, in general, how often did this happen?

- Less than 1 day a week  
 1 day a week  
 2 or 3 days a week  
 4 or 5 days a week  
 Almost every day

8. When you ate a very large amount of food and you could not control your eating, did you:
- a. Eat very fast? .....  Yes  No
  - b. Eat until your stomach hurt or you felt sick in your stomach? .....  Yes  No
  - c. Eat very large meal/amount of food even when you were not hungry? .....  Yes  No
  - d. Eat very large meal/amount of food during the day without regular meals like breakfast, lunch, dinner? .....  Yes  No
  - e. Eat by yourself because you did not want anyone to see how much you ate? .....  Yes  No
  - f. Feel *really bad* about yourself after eating a lot of food? .....  Yes  No
9. Have you ever taken medicine (pills, liquid, gum, powder) that would make you go to the bathroom in order to not gain weight after eating a very large amount of food? .....  Yes  No

Were these laxatives (makes you have a bowel movement) or diuretics (makes you urinate)? Check which one(s). .....  Laxatives  Diuretics  Don't Know

Did you ever take more than twice the amount you were told to take on the box or bottle? .....  Yes  No

How often, on average, did you do that?

- Less than once a week  
 Once a week  
 2 or 3 times a week  
 4 or 5 times a week  
 More than 5 times a week

10. Did you ever not eat anything at all for at least 24 hours (a full day) to keep from gaining weight after eating a very large amount of food? .....  Yes  No

Patient's Name: \_\_\_\_\_

How often, on average, did you do that?

- Less than once a week
- Once a week
- 2 or 3 times a week
- 4 or 5 times a week
- More than 5 times a week

11. Did you ever exercise for more than one hour at a time only to keep from gaining weight after eating a very large amount of food? .....  Yes  No

How often, on average, did you do that?

- Less than once a week
- Once a week
- 2 or 3 times a week
- 4 or 5 times a week
- More than 5 times a week

12. During the past 3 months, did you ever take diet pills to keep from gaining weight after eating a really big amount of food? .....  Yes  No

Did you ever take more than twice the amount you were told to take on the box or bottle? .....  Yes  No

How often, on average, did you do that?

- Less than once a week
- Once a week
- 2 or 3 times a week
- 4 or 5 times a week
- More than 5 times a week

*Exercise Habits*

1. First, we are interested in the number of flights of stairs you climbed up on average each day in the past week. We only want to know the number of flights you climbed going up – not down. If you know the number of steps, let 1 flight - 10 steps.
2. In the past week, I walked an average of \_\_\_\_\_ blocks per day
3. If you walk as part of an exercise program, how far do you walk? ..... \_\_\_\_\_  
How many times per week. \_\_\_\_\_
4. Do you now or have you ever needed a wheelchair or other assistive devices such as canes or walkers? .....  Yes  No  
Please describe \_\_\_\_\_

Patient's Name: \_\_\_\_\_

5. Were there any sports, recreational, or physical activities in which you participated during the past week? If so, please list each sport/activity, the number of times you participated, and the time spent engaged in the activity (please count only the time during which you were physically active). (Do not include walking outside – use question 3 for walking done outside.)

Sport or Recreation	Number of Times / Week	Average Time/ Episode (mins)
a.		
b.		
c.		
d.		
e.		
f.		
g.		

6. At least once a week, do you engage in any regular activity similar to brisk walking, jogging, bicycling, etc., long enough to work up a sweat? .....  Yes  No

If yes, list the activity

- a. \_\_\_\_\_ times/week
- b. \_\_\_\_\_ times/week
- c. \_\_\_\_\_ times/week

7. On average, how many hours per week do you spend watching TV/Cable/VCR?

- 0 to 1 hour/week
- 2 to 5 hours/week
- 6 to 10 hours/week
- 11 to 20 hours/week
- 21 to 40 hours/week
- 61 or more hours/week

Patient's Name: \_\_\_\_\_

8. Excluding time spent watching TV/Cable/VCR, how many hours per week do you spend sitting (e.g., working at a desk, relaxing on the couch)?

- 0 to 1 hour/week
- 2 to 5 hours/week
- 6 to 10 hours/week
- 11 to 20 hours/week
- 21 to 40 hours/week
- 61 or more hours/week

9. Would you say that during the past week you were:

- Less active than usual
- More active than usual
- About as active as usual

*Previous Diagnostic Procedures:*

Please list any laboratory diagnostic procedures within the last year. Please indicate what month they were performed.

- |                                                    |                                                |                                                  |
|----------------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> EKG                       | <input type="checkbox"/> Chest X-Ray           | <input type="checkbox"/> Echocardiogram          |
| <input type="checkbox"/> Stress Test               | <input type="checkbox"/> Heart Catheterization | <input type="checkbox"/> Upper GI                |
| <input type="checkbox"/> Barium Enema              | <input type="checkbox"/> Upper Endoscopy       | <input type="checkbox"/> Abdominal Sonogram      |
| <input type="checkbox"/> Colonoscopy               | <input type="checkbox"/> Sleep Study           | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> CT Scan (Body Area) _____ | <input type="checkbox"/> Blood Work _____      |                                                  |
| <input type="checkbox"/> Other _____               |                                                |                                                  |
-

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS:** This questionnaire asks for your views about your health. This information will help us keep track of how you feel and how well you are able to do your usual activities.

Place only one check on the line to indicate your **BEST ANSWER**.

1. In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

If you are unsure how to answer a question, please give the best answer you can. (Check only one response to each question.)

Activities	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. Vigorous activities, such as running, lifting heavy objects, and participating in strenuous sports			
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
c. Lifting or carrying groceries			
d. Climbing several flights of stairs			
e. Climbing one flight of stairs			
f. Bending, kneeling or stooping			
g. Walking more than a mile			
h. Walking several blocks			
i. Walking one block			
j. Bathing or dressing yourself			

4. During the past 4 weeks, have you had any of the following problems with your work or regular daily activities as a result of your physical health? (Mark one box on each line.)

- a. Cut down the amount of time you spent on work or other activities .....  Yes  No
- b. Accomplished less than you would like .....  Yes  No
- c. Were limited in the kind of work or other activities .....  Yes  No
- d. Had difficulty performing the work or other activities (for example, it took extra effort)...  Yes  No

Patient's Name: \_\_\_\_\_

5. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? (Mark one box on each line.)
- a. Cut down the amount of time you spent on work or other activities. ....  Yes  No
  - b. Accomplished less than you would like. ....  Yes  No
  - c. Didn't do work or other activities as carefully as usual. ....  Yes  No
6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, groups?
- Not at all
  - Slightly
  - Moderately
  - Quite a bit
  - Extremely
7. How much bodily pain have you had during the past 4 weeks? (Mark only one box.)
- None  Moderate
  - Very Mild  Severe
  - Mild  Very Severe
8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Mark only one box.)
- Not at all
  - Slightly
  - Moderately
  - Quite a bit
  - Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

9.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of pep?						
b. Have you been a very nervous person?						
c. Have you felt so down in the dumps that nothing could cheer you up?						
d. Have you felt calm and peaceful?						
e. Did you have a lot of energy?						
f. Have you felt downhearted and blue?						
g. Did you feel worn out?						
h. Have you been a happy person?						
i. Did you feel tired?						

Patient's Name: \_\_\_\_\_

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Mark only one box.)

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

11. How true or false is each of the following statements for you? (Mark only one for each question.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people.					
b. I am as healthy as anybody I know.					
c. I expect my health to get worse.					
d. My health is excellent.					

12. a. Which are you? .....  Male  Female

12. b. How old were you on your last birthday?

- Less than 35
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 and older

13. Have you ever filled out this form before? .....  Yes  No  Don't Remember

**Patient's Name:** \_\_\_\_\_

*Please list any specific question(s) that you would like to discuss with the surgeon at your appointment.*

---

---

---

---

---

---

---

---

---

---

This information is very important to give you the best possible medical/surgical care. We express thanks for taking the time and energy to complete this worksheet.

Thank you,

Dr. J. Matthew Glascock and Dr. M. Cameron Hodges