ARIZONA Weight Loss Solutions

History Packet | Please Print

First Name:____

Middle Name:____

Last Name:____

Date of Birth:____/____/______ (mm/dd/yyyy) Gender: ___Female ___Male

Social Security Number ________/______/__________ Ethnicity:__________________

Street Address:____

City:_________________________State:___________________Zip:_______________

E-mail:____@_____________________

Home Phone: (_____)______-_________ Can we leave a message on this number? __Yes __No

Work Phone: (_____)______-_________ Can we leave a message on this number? __Yes __No

Cell Phone: (_____)______-_________ Can we leave a message on this number? __Yes __No

Religious affiliation:______________________ Patient's level of education:__________

Primary/Referring Doctor or Insurance:

- None (you were not referred to our program by a Physician)

- You were referred to our program by your Physician or Insurance
  Name:_____________________________Practice Name__________________
  Address:____
  City:__________________________State:_______________Zip:_____________

Phone:(_______)________-___________

Patient's Employment Status:______________________

- If disabled, specify the year and cause: Year________Cause________________

Patient's occupation (indicate if student):_________________________________

Patient's employer:____

Years employed:_______________

Patient's employer's address:____

____

Insurance Info

Primary

Co. Name________________________

Address_________________________

ID#_____________________________

Primary Insured___________________

Insured DOB_____________________

Secondary

Co. Name________________________

Address_________________________

ID#_____________________________

Primary Insured___________________

Insured DOB_____________________

Responsible Party (If different than above)

Responsible Party Name____

Employer_______________________________Social Security#_______/_____/______

Home Address____

City_________________________________State______________Zip_____________

Primary Phone_____________________________Work________________________

I authorize release of any medical information necessary to process this claim request payment of benefits, either to myself or the party who accepts assignment/participates. If assignment is not accepted, I understand that I am responsible for the full amount of services charged. ______**Initial**

I acknowledge I was offered a copy of the privacy practices. ______**Initial**

Emergency Contact #1:

First Name:________________________Last Name:__________________________

Relationship to you:_____________________ Phone (_______)________-_________

Emergency Contact #2:

First Name:________________________Last Name:__________________________

Relationship to you:_____________________ Phone (_______)________-_________

Reason for visit(i.e. why are you seeking weight loss surgery?)

____

____

____

How did you hear about us?

- Doctor
- Patient
- Friend
- TV
- Magazine
- Insurance

Any specific questions you need addressed? ______________________________

____

____

What made you decide that now was the time for weight loss surgery?

- o Deteriorating health
- o Poor quality of life/unable to participate in family activities
- o Advise of physician
- o Insurance/monetary issues
- o Other

  If other, please specify:____

Allergic Reactions to Medications/Food ______ **Yes** ______ **No**
Please list all medications/foods you are allergic to or have adverse effects from:

Med/Food________________________________ Reaction____________________________

Med/Food________________________________ Reaction____________________________

Med/Food________________________________ Reaction____________________________

Med/Food________________________________ Reaction____________________________

Med/Food________________________________ Reaction____________________________

Medication Information: It is important that we know what medications you are currently taking. Please help us by providing, accurate, detailed information.

Medication:_______________________________ Strength:___________________________

Directions:_________________________________ Reason:____________________________

Prescribed By:____

Medication:_______________________________ Strength:___________________________

Directions:_________________________________ Reason:____________________________

Prescribed By:____

Medication:_______________________________ Strength:___________________________

Directions:_________________________________ Reason:____________________________

Prescribed By:____

Medication:_______________________________ Strength:___________________________

Directions:_________________________________ Reason:____________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Medication:_____________________________ Strength:_________________________

Directions:_______________________________ Reason:__________________________

Prescribed By:_______________________________________

Weight-Loss Surgery

- What is your height? _____ft. _____in.
- How much do you weigh? ______lbs.
- BMI:___________
- From what age have you been obese? _____years.
- For how many years have you been at your current weight? ______years.
- What was your maximum adult weight? _____lbs
- What was your minimum adult weight? _____lbs.
- What is the most weight you ever lost on a single diet? _____lbs.
- How many months did you keep it off ? _____months.
- What was your weight at the following ages?(Please estimate)

Age 10: _____lbs. Age 18: _____lbs. Age 25: _____lbs.
Age 30: _____lbs. Age 35: _____lbs. Age 40: _____lbs.
Age 45: _____lbs. Age 50: _____lbs. Age 60+_____lbs.

Unsupervised diet attempts (Check all that apply and enter the weight lost with each attempt)

- o No diet attempts of any kind.

Diet	Lost	Regained	Started (mm/yyyy)	Duration
o Body for Life/Bill Phillips	_______lbs.	_______lbs.	____/______	________mo.
o Gloria Marshall	_______lbs.	_______lbs.	____/______	________mo.
o Health Spa	_______lbs.	_______lbs.	____/______	________mo.
o High Protein	_______lbs.	_______lbs.	____/______	________mo.
o Hypnosis	_______lbs.	_______lbs.	____/______	________mo.
o Low Carbohydrate	_______lbs.	_______lbs.	____/______	________mo.
o Low Fat	_______lbs.	_______lbs.	____/______	________mo.
o Calorie Counting	_______lbs.	_______lbs.	____/______	________mo.
o Pritikin	_______lbs.	_______lbs.	____/______	________mo.
o Richard Simmons	_______lbs.	_______lbs.	____/______	________mo.
o Scardale	_______lbs.	_______lbs.	____/______	________mo.
o Stillman Diet	_______lbs.	_______lbs.	____/______	________mo.
o Sugar Busters	_______lbs.	_______lbs.	____/______	________mo.
o Slim Fast	_______lbs.	_______lbs.	____/______	________mo.
o Mayo Clinic	_______lbs.	_______lbs.	____/______	________mo.
o Other 1:_____________	_______lbs.	_______lbs.	____/______	________mo.
o Other 2:_____________	_______lbs.	_______lbs.	____/______	________mo.
o Other 3:_____________	_______lbs.	_______lbs.	____/______	________mo.

Supervised Diet Attempts (Check all that apply and enter the weight lost with each attempt)

Diet	Lost	Regained	Started (mm/yyyy)	Duration
o Nutri-Systems	_______lbs.	_______lbs.	____/______	________mo.
o Diet Center	_______lbs.	_______lbs.	____/______	________mo.
o Overeaters Anonymous	_______lbs.	_______lbs.	____/______	________mo.
o Optifast	_______lbs.	_______lbs.	____/______	________mo.
o Weight Watchers	_______lbs.	_______lbs.	____/______	________mo.
o T.O.P.S.	_______lbs.	_______lbs.	____/______	________mo.
o Jenny Craig	_______lbs.	_______lbs.	____/______	________mo.
o New Direction	_______lbs.	_______lbs.	____/______	________mo.
o National Weight Loss	_______lbs.	_______lbs.	____/______	________mo.
o HMR-Health Management Resources	_______lbs.	_______lbs.	____/______	________mo.
o Other 1:____________	_______lbs.	_______lbs.	____/______	________mo.
o Other 2:____________	_______lbs.	_______lbs.	____/______	________mo.
o Other 3:____________	_______lbs.	_______lbs.	____/______	________mo.

Medications Prescribed for Weight Loss (Medications may be listed both as generic and name brand. Check all medications that you have taken for weight loss.)

o No Weight Loss medications.

Medication	Lost	Regained	Started (mm/yyyy)	Duration
o Acutrim	________lbs.	________lbs.	____/______	_________mo.
o Amphetamines	________lbs.	________lbs.	____/______	_________mo.
o Anorex	________lbs.	________lbs.	____/______	_________mo.
o Benzphetamine	________lbs.	________lbs.	____/______	_________mo.
o Dexatrim(Phentermine)	________lbs.	________lbs.	____/______	_________mo.
o Didrex	________lbs.	________lbs.	____/______	_________mo.
o Fastin	________lbs.	________lbs.	____/______	_________mo.
o Fen-Phen	________lbs.	________lbs.	____/______	_________mo.
o Ionamin/Adipex (Phentermine)	________lbs.	________lbs.	____/______	_________mo.
o Mazanor	________lbs.	________lbs.	____/______	_________mo.
o Meridia (Sibutramine)	________lbs.	________lbs.	____/______	_________mo.
o Obalan	________lbs.	________lbs.	____/______	_________mo.
o Phendiet	________lbs.	________lbs.	____/______	_________mo.
o Phentrol	________lbs.	________lbs.	____/______	_________mo.
o Plegine	________lbs.	________lbs.	____/______	_________mo.
o Pondimin (Fenfluramine)	________lbs.	________lbs.	____/______	_________mo.
o Prozac (Fluoxetine)	________lbs.	________lbs.	____/______	_________mo.
o Redux(Dexfenfluramine)	________lbs.	________lbs.	____/______	_________mo.
o Sanorex	________lbs.	________lbs.	____/______	_________mo.
o Tepanol	________lbs.	________lbs.	____/______	_________mo.
o Tenuate	________lbs.	________lbs.	____/______	_________mo.
o Wehless	________lbs.	________lbs.	____/______	_________mo.
o Xenical(Orlistat)	________lbs.	________lbs.	____/______	_________mo.

Behavioral Treatments for Weight Loss (Please check all behavioral treatments that you have had while attempting to lose weight)

o No behavioral treatments

Treatment	Lost	Regained	Started (mm/yyyy)	Duration
o Hypnosis	________lbs.	________lbs.	____/______	_________mo.
o Hospitalization	________lbs.	________lbs.	____/______	_________mo.
o Psychologist Therapy	________lbs.	________lbs.	____/______	_________mo.
o Residential Programs	________lbs.	________lbs.	____/______	_________mo.

Surgical/Hospitalization History

			Month/Year
Gallbladder (Open)	○Yes	○No	____/______
Gallbladder (Laparoscopic)	○Yes	○No	____/______
Appendectomy	○Yes	○No	____/______
Hysterectomy(uterus removed			

Vaginally)	○Yes	○No	____/______
Hysterectomy(uterus removed- Abdominal)	○Yes	○No	____/______
Ovary Surgery	○Yes	○No	____/______
Cesarean Section	○Yes	○No	____/______
Back	○Yes	○No	____/______
Right knee	○Yes	○No	____/______
Left knee	○Yes	○No	____/______
Right breast biopsy	○Yes	○No	____/______
Left breast biopsy	○Yes	○No	____/______
Previous Weight-Loss Surgery	○Yes	○No	____/______
Tonsillectomy	○Yes	○No	____/______
Hernia	○Yes	○No	____/______
Tubal Ligation	○Yes	○No	____/______
Kidney Transplant	○Yes	○No	____/______
Liver Transplant	○Yes	○No	____/______
Pancreas Transplant	○Yes	○No	____/______
Other 1:____________________	○Yes	○No	____/______
Other 2:____________________	○Yes	○No	____/______
Other 3:____________________	○Yes	○No	____/______
Other 4:____________________	○Yes	○No	____/______
Other 5:____________________	○Yes	○No	____/______
Other 6:____________________	○Yes	○No	____/______

Review of Systems

Cardiovascular

Heart attack	○Yes	○No
Angina (chest pain with activity)	○Yes	○No
Rhythm disturbance/palpitations	○Yes	○No
Congestive heart failure	○Yes	○No
High blood pressure	○Yes	○No
Ankle swelling	○Yes	○No
Varicose veins	○Yes	○No
Hemorrhoids	○Yes	○No
Phlebitis	○Yes	○No
Ankle/leg ulcers	○Yes	○No
Heart bypass/valve replacement	○Yes	○No
Pacemaker	○Yes	○No
Clogged heart arteries	○Yes	○No
Rheumatic fever/valve damage	○Yes	○No
Heart murmur	○Yes	○No
Irregular heart beat	○Yes	○No
Cramping in legs when walking	○Yes	○No
Other symptoms	○Yes	○No

Respiratory

Asthma	○Yes	○No
Emphysema	○Yes	○No
Bronchitis	○Yes	○No

Pneumonia	○Yes	○No
Chronic cough	○Yes	○No
Short of breath	○Yes	○No
Use of CPAP or oxygen supplement	○Yes	○No
Tuberculosis	○Yes	○No
Pulmonary embolism	○Yes	○No
Hypoventilation syndrome	○Yes	○No
Cough up blood	○Yes	○No
Snoring	○Yes	○No
Sleep apnea	○Yes	○No
Lung surgery	○Yes	○No
Lung cancer	○Yes	○No

Endocrine

Hypothyroid (low)	○Yes	○No
Hyperthyroid (high/overactive)	○Yes	○No
Goiter	○Yes	○No
Parathyroid	○Yes	○No
Elevated cholesterol	○Yes	○No
Elevated triglycerides	○Yes	○No
Low blood sugar	○Yes	○No
Diabetes (managed by diet or pills)	○Yes	○No
Diabetes (needing insulin shots)	○Yes	○No
“Prediabetes” with elevated blood sugar	○Yes	○No
Gout	○Yes	○No
Endocrine gland tumor	○Yes	○No
Cancer of endocrine gland	○Yes	○No
High calcium level	○Yes	○No
Abnormal facial hair growth	○Yes	○No
Osteoporosis	○Yes	○No

Gastrointestinal

Heartburn	○Yes	○No
Hiatal hernia	○Yes	○No
Ulcers	○Yes	○No
Diarrhea	○Yes	○No
Blood in stool	○Yes	○No
Change in bowel habit	○Yes	○No
Constipation	○Yes	○No
Irritable bowel	○Yes	○No
Colitis	○Yes	○No
Crohns	○Yes	○No
Hemmorrhoids	○Yes	○No
Fissure	○Yes	○No
Rectal bleeding	○Yes	○No
Black, tarry stools	○Yes	○No
Polyps	○Yes	○No
Abdominal pain	○Yes	○No
Enlarged liver	○Yes	○No
Cirrhosis/hepatitis	○Yes	○No
Gallbladder problems	○Yes	○No

Jaundice	○Yes	○No
Pancreatic disease	○Yes	○No
Unusual vomiting	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Bladder/Kidney

Kidney Stones	○Yes	○No
Blood in urine	○Yes	○No
Prostate problems	○Yes	○No
Kidney failure	○Yes	○No
Leaking urine	○Yes	○No
For men: PSA test in the last year?	○Yes	○No
Burning on urination	○Yes	○No
Loss of bladder control leakage?	○Yes	○No
Trouble starting urine	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Gynecologic (for women only)

Problems conceiving (infertility)	○Yes	○No
Are you pregnant?	○Yes	○No
Uterine/Ovarian Cancer?	○Yes	○No
Surgery	○Yes	○No
Menstrual irregularity	○Yes	○No
Menstrual pain	○Yes	○No
Excessively heavy periods	○Yes	○No
Do you plan to have more children?	○Yes	○No
Are you post menopausal?	○Yes	○No
Date of menopausal onset:	____/____/_________	
Date of last pap smear:	____/____/_________	
Date of last menstrual period:	____/____/_________	
Age started menses:	__________	
How many pregnancies have you had?	__________	
How many children have you had?	__________	
How many miscarriages or abortions have you had?	__________	
Date of last Mammogram (35+)	____/____/_________	
DEXA Scan (Bone Density) (50+) ___N/A	○Yes	○No

Musculoskeletal

Arthritis	○Yes	○No
Neck pain	○Yes	○No
Shoulder pain	○Yes	○No
Wrist pain	○Yes	○No
Back pain	○Yes	○No
Hip pain	○Yes	○No
Knee pain	○Yes	○No
Ankle pain	○Yes	○No
Foot pain	○Yes	○No
Heel pain	○Yes	○No
Ball of foot/toe pain	○Yes	○No

Plantar fasciitis	○Yes	○No
Carpal tunnel syndrome	○Yes	○No
Lupus	○Yes	○No
Scleroderma	○Yes	○No
Sciatica	○Yes	○No
Autoimmune disease	○Yes	○No
Muscle pain spasm	○Yes	○No
Fibromyalgia	○Yes	○No
Broken bones	○Yes	○No
Joint replacement	○Yes	○No
Nerve injury	○Yes	○No
Muscular dystrophy	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Head and Neck

Wear contacts/glasses	○Yes	○No
Vision problems	○Yes	○No
Hearing problems	○Yes	○No
Sinus drainage	○Yes	○No
Neck lumps	○Yes	○No
Swallowing difficulty	○Yes	○No
Dentures/partial	○Yes	○No
Oral sores	○Yes	○No
Hoarseness	○Yes	○No
Head/Neck Surgery	○Yes	○No
Cancer	○Yes	○No

Neurologic

Migraine headaches	○Yes	○No
Balance disturbance	○Yes	○No
Seizure or convulsions	○Yes	○No
Weakness	○Yes	○No
Stroke	○Yes	○No
Alzheimer’s	○Yes	○No
Pseudotumor cerebri (loss of vision from high pressure In the brain)	○Yes	○No
Multiple Sclerosis	○Yes	○No
Frequency severe headaches	○Yes	○No
Knocked unconscious	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Breast

Lumps	○Yes	○No
Pain	○Yes	○No
Fibrocystic disease	○Yes	○No
Nipple discharge	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Skin

Rashes under skin folds	○Yes	○No
Keloids (excessively raised scars)	○Yes	○No
Poor wound healing	○Yes	○No
Frequent skin infections	○Yes	○No
Surgery	○Yes	○No
Cancer	○Yes	○No

Blood

Anemia (iron deficient)	○Yes	○No
Anemia (vitamin B12 deficient)	○Yes	○No
HIV	○Yes	○No
Low platelets (thrombocytopenia)	○Yes	○No
Lymphoma	○Yes	○No
Swollen lymph nodes	○Yes	○No
Superficial blood clot in leg	○Yes	○No
Deep blood clot in leg	○Yes	○No
Blood clot in lungs (pulmonary embolism)	○Yes	○No
Bleeding disorder	○Yes	○No
Blood transfusion	○Yes	○No
Blood and thinning medicine use	○Yes	○No

Psychiatric

Anxiety	○Yes	○No
Depression	○Yes	○No
Anorexia (starvation to control weight)	○Yes	○No
Bulimia (excessive vomiting to control weight)	○Yes	○No
Bipolar disorder (“manic-depression”)	○Yes	○No
Alcoholism	○Yes	○No
Drug dependency	○Yes	○No
Schizophrenia	○Yes	○No
Other psychiatric problems	○Yes	○No
Hospitalization for psychiatric problems	○Yes	○No
Have you ever been in a psychiatric hospital?	○Yes	○No
Have you ever attempted suicide?	○Yes	○No
Have you ever been physically abused?	○Yes	○No
Have you ever been sexually abused?	○Yes	○No
Have you ever seen a psychiatrist or counselor?	○Yes	○No
Have you ever taken medications for psychiatric Problems or for depression?	○Yes	○No
Have you ever been in a chemical dependency program?	○Yes	○No

Constitutional

Fevers	○Yes	○No
Night Sweats	○Yes	○No
Anemia	○Yes	○No
Weight Loss	○Yes	○No
Chronic fatigue	○Yes	○No
Hair loss	○Yes	○No

Social History

Tobacco Use:
Do you smoke now? ○Yes ○No

If yes, how many cigarettes and/or packs per day? _________

Do you use snuff or chew? ○Yes ○No

If yes, how frequently do you use snuff/chew? _________

For how many years have/did you use tobacco? _________

If you have quit, how long ago? _________

Alcohol Use:

Do you consume alcohol now? ○Yes ○No

If yes, how many times a week? _________

If yes, how many drinks each time? _________

For how many years do/did you drink alcohol? _________

If you have quit, how long ago? _________

Is anyone concerned about the amount you drink? _________

Drug Use:
Have you ever used recreational drugs? ○Yes ○No

Have you used street in the past year? ○Yes ○No

If yes, which drugs? _______________________

If yes, how frequently do you use these drugs? _______________________

Caffeine Use:
Do you drink coffee or caffeine beverages? ○Yes ○No

If yes, how many cups per day? _________Cups

Do you drink carbonated beverages? ○Yes ○No

If yes, how many cans per day? _________Cans

Lifestyle:
On a scale of 1 to 5 (1=least satisfied; 5=very satisfied), rate the following situations in your life:

Married life?	○1	○2	○3	○4	○5
Present job?	○1	○2	○3	○4	○5
Overall satisfaction with yourself?	○1	○2	○3	○4	○5

What hobbies do you have that are important to you?
____
____
____.

How many hours a day do you watch TV? ○Never ○Rarely ○3-5hrs. ○5+

If you are disabled, Why? ○Physical ailments ○Mental ailments

Could someone help care for you if you were seriously ill? ○Yes ○No
If yes, who?____

Are there people for whom you are the primary care giver? ○Yes ○No
If yes, who?____

Do you have children? ○Yes ○No
If yes, how many?_________

Have you used any of the following to control your weight? (check all that apply)
○Bingeing and purging ○Bingeing followed by food restriction
○Diuretics ○Laxatives
○Vomiting

If so, when and for how long was this period of behavior?
____
____.

Why do you eat?
○Physical hunger ○Loneliness ○Anxiousness
○Makes me happy ○Bored

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?
____.

What reasons do you feel contribute to you being overweight?
○ Inactivity ○ Emotional well-being ○Over Consumption

How do you personally account for why you have not been able to lose weight?
____
____
____.

Do you have a history of abuse? Please include emotional, physical, mental, substance, or other types of abuse issues you have dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan. ○ Yes ○ No

Describe your present life stressors: (check all that apply)
○ Family ○Finances ○Friends ○ Illness ○ Work

Describe the present support system you rely upon :(check all that apply)
○ Church ○Co-Workers ○ Family ○Friends ○Others ○Spouse

Describe your work and home life (family members, etc.). Do you have support at home?

____
____
____
____.

What is your greatest fear regarding the surgery?

____
____
____.

What is motivating you to seek this type of interventions for weight control?

____
____
____.

Adopted? ○ Yes ○ No

If you are not adopted, please continue.

Family History

Obesity	○ Yes	○ No
Kidney disease	○ Yes	○ No
Heart disease	○ Yes	○ No
Pulmonary edema	○ Yes	○ No
Diabetes Mellitus	○ Yes	○ No
High blood pressure	○ Yes	○ No
Alcoholism	○ Yes	○ No
Liver problems	○ Yes	○ No
Lung problems	○ Yes	○ No
Bleeding disorder	○ Yes	○ No
Gallstones	○ Yes	○ No
Mental Illness	○ Yes	○ No
Malignant hyperthermia	○ Yes	○ No
Cancer	○ Yes	○ No

Type: ○Breast ○Uterine ○Ovarian ○Prostate ○Colon ○Other

Gastrointestinal Cancers ○ Yes ○ No

If other, please specify type:____

Number of family deaths related to obesity? _______

Please add any additional information you feel pertinent to your current health condition.

____
____
____
____
____
____
____
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____
____
____
____
____
____
____

____ ________________
Signature Date