REAL Weight Loss Solutions at
St. John Detroit Riverview

Phone: 586.276.8130 Fax: 586.276.8101
31700 Van Dyke, Suite 110
Warren, MI 48093
www.realmedicine.org/riverviewweightloss/

HEALTH HISTORY PROFILE

Please complete the following pages thoroughly. The information contained within this form will be used to provide the best care for you and to obtain insurance authorization for your procedure. (Please print)

NAME:______________________________ DATE:________________

AGE:________ HEIGHT:________ WEIGHT:_________

Day time phone #:_________________________

WEIGHT HISTORY

Life Event	Age	Weight
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		
1st Pregnancy		
Last Pregnancy		

PAST WEIGHT LOSS ATTEMPTS

Diet Name	Year	Length of Time	Weight Lost	Weight Regained
	Last 6 months			
	This Year			
	Last Year			
	2 Years Ago			

Drug treatment prescribed by a physician (Meridia, Xenical, Redux etc…)
Name of drug:____________________ Duration:______________

Weight Lost:__________ Weight Regained: __________

Reason medication was stopped:____

Have you ever taken Phen-Fen OR Redux? Yes No If yes, did you have an echocardiogram? Yes No

Inpatient weight loss program: Name:____
Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Diet Shots Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Medically Supervised Weight Loss: Name of physician or program:________________________
Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Medifast Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Nutritionist Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Optifast Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Other Forms of Weight Loss

Acupuncture Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Appetite Suppressants Duration:____________ Pounds Lost:_________ Pounds Regained:__________

Atkins Diet Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Body Solutions Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Cabbage Soup Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Exercise Videos Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Gastric Bubble Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Gym Membership/Trainer- Name of gym:______________________
Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Herbalife Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Hypnosis Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Jaw Wiring Duration:______________ Pounds Lost:_________ Pounds Regained:_________

Jenny Craig Duration:______________ Pounds Lost:_________ Pounds Regained:_________

LA Diet Duration:______________ Pounds Lost:_________ Pounds Regained:_________

PATIENT NAME:____

Low Carbohydrate Diet Duration:_______________ Pounds Lost:_________ Pounds Regained:_________

Low Cholesterol Diet Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Mayo Clinic Diet Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Metabolife Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

NutriSystem Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Over Eater's Anonymous Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Pritikin Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Reduced Calorie Diet 1000/1500/1800
Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Richard Simmons Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Scarsdale Diet Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Slim Fast Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

South Beach Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Sugar Busters Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

T.O.P.S. Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Vegetarian Diet Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Weight Watchers Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

Zone Diet Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

OTHER Name:_____________________________

Duration:_______________ Pounds Lost:__________ Pounds Regained:__________

SOCIAL HISTORY

Religion: ____________________ Level of Education:_____________________________________

Number of Persons Living in the Home:______________

Smoking History: Never Former Smoker Year Quit: ____________

CURRENTLY Smoking Number of packs per day: ____________ Number of years: ____________

All patients who currently smoke are required to quit FOUR WEEKS prior to surgery

Recreational Drug Use: Yes No Describe:______________________________________

Coffee/Caffeine Intake: Yes No _______ Cups per day

Carbonated Beverages: Yes No _______ Sodas per day

Alcohol Intake: Yes No _______Drinks per day

Alcohol is not to be consumed TWO WEEKS prior to surgery

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses and operations you have experienced.

? Rheumatic fever Year:________________ ? Heart murmur Year:________________

? Obesity Year:________________ ? Bleeding disorders Year:________________

? Appendectomy Year:________________ ? Tonsillectomy Year:________________

? Asthma Year:________________

Female patients only

Do you have a regular Menstrual Cycle (26 – 33 days) Yes No

Excessively heavy Menstrual Cycle Yes No

Difficulty with Conceiving Yes No

Are you currently having problems with infertility Yes No

Have you ever been told by a doctor that you have polycystic ovaries Yes No

Have you had a caesarean section Yes No

Currently pregnant Yes No

PATIENT NAME:____

Number of pregnancies: ________________ Date of last period: ________________

Number of live births: ________________ Miscarriages/abortions: ________________

Obstetric complications:

____

____

Do you presently use the following?

Birth control pills	Yes	No	List Type: ____________________
IUD	Yes	No	List Type: ____________________
Estrogens	Yes	No	List Type: ____________________
Hormone Replacement Therapy	Yes	No	List Type: ____________________

Please list below all serious illnesses and hospitalizations you have experienced in <u>adulthood.</u>

Major Illness	**Date**	**Treatment**

<u>Major Surgery</u>

________________________________ Year ________________

________________________________ Year ________________

________________________________ Year ________________

<u>Past surgical complications</u>

Difficulty with anesthesia	Yes	No
Difficulty healing	Yes	No
Bleeding problems	Yes	No
Blood clots (Deep Vein Thrombosis or Pulmonary Embolism)	Yes	No
Pneumonia	Yes	No
Allergy to surgical tape/latex	Yes	No

PATIENT NAME: ____

Have you ever had swelling, itching, or hives after being examined by medical professional wearing rubber or latex gloves? Yes No

Are you allergic to seafood, eggs, iodine, nuts, or milk? Yes No

Drug Allergies **Drug** **Reaction** ______**ö Here if NONE**

____

____

FAMILY MEDICAL HISTORY

	PARENT	SIBLING	OTHER RELATIVES	NO FAMILY HISTORY	DON'T KNOW
Obesity					
Diabetes					
Heart Disease					
Hypertension					
High Cholesterol					
Sleep Apnea					
Asthma					
Stroke					
Cancer					
Blood clots					
Depression					
Osteoporosis					

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

CARDIOVASCULAR:

Varicose Veins Yes No Details:______________________________

Venous Stasis Disease Yes No Details:______________________________

Swelling of Ankles/Feet Yes No Details:______________________________

Deep Vein Thrombosis- DVT (Blood clot in leg) Yes No Details:______________________________

PATIENT NAME:____

Pulmonary Embolism (Blood clot in lung)	Yes	No	Details:________________
High Cholesterol	Yes	No	Details:________________
High Triglycerides	Yes	No	Details:________________
High Blood Pressure	Yes	No	Details:________________
Palpitations	Yes	No	Details:________________
Angina (chest pain)	Yes	No	Details:________________
M.I. (myocardial infarction, heart attack)	Yes	No	Details:________________
CABG (coronary artery bypass graft, known as open heart surgery)	Yes	No	Details:________________
Cardiomyopathy	Yes	No	Details:________________
Abnormal EKG	Yes	No	Details:________________
Arrhythmia	Yes	No	Details:________________
Shortness of breath	Yes	No	Details:________________

Stress test to rule out cardiac problems Date:________________

Echocardiogram (heart ultrasound) Date:________________

ENDOCRINOLOGY:

Diabetes	Yes	No	Details:________________
Do you take Insulin	Yes	No	Details:________________
Oral Medication	Yes	No	Details:________________
Diabetes with pregnancy	Yes	No	Details:________________
Glucose Intolerance	Yes	No	Details:________________
Hyperthyroidism	Yes	No	Details:________________
Hypothyroidism	Yes	No	Details:________________
Goiter	Yes	No	Details:________________
Grave's Disease	Yes	No	Details:________________

PULMONARY

Asthma	Yes	No	Details:________________
Hospitalization in last 2 years	Yes	No	Details:________________
Steroid use in last 2 years	Yes	No	Details:________________
Do you snore?	Yes	No	Details:________________
Do you wake at night with a choking feeling?	Yes	No	Details:________________

PATIENT NAME:____

Do you have a headache when you wake up in the morning?

Yes No Details:__________________________________

Do you feel sleepy during the day?

Yes No Details:__________________________________

Have you ever been told you stop breathing in your sleep?

Yes No Details:__________________________________

Sleep Apnea Yes No Details:__________________________________

CPAP or BiPAP Yes No Details:__________________________________

Year diagnosed: ________________ Last sleep study: ________________

Emphysema Yes No Details:__________________________________

Chronic Obstructive Pulmonary Disease (COPD)

Yes No Details:__________________________________

GASTROINTESTINAL

Heart burn Yes No Details:__________________________________

Hiatal hernia Yes No Details:__________________________________

Ulcer Yes No Details:__________________________________

Gastritis Yes No Details:__________________________________

Constipation Yes No Details:__________________________________

Diarrhea Yes No Details:__________________________________

Colitis Yes No Details:__________________________________

Irritable Bowel Syndrome Yes No Details:__________________________________

Crohn’s Disease Yes No Details:__________________________________

Hepatitis or Liver disease Yes No Details:__________________________________

Rectal Bleeding Yes No Details:__________________________________

GALLBLADDER

Gallbladder disease Yes No Details:__________________________________

Gallbladder removed Yes No Details:__________________________________

Ultrasound performed Yes No Details:__________________________________

GENITO-URINARY:

Renal / kidney failure Yes No Details:__________________________________

Leakage of urine with laughing/coughing/ sneezing Yes No Details:__________________________________

Wear pads frequently Yes No Details:__________________________________

MUSCULOSKELETAL:

Gout Yes No Details:____________________

Arthritis Yes No Details:____________________

Low back strain/pain/sciatica Yes No Details:____________________

Pain in hips/knees/ankles/feet Yes No Details:____________________

Assistance to ambulate Yes No Details:____________________

Exercise limitation: (CIRCLE ONE) None / Minimal / Severe

CANCER

Breast Yes No Details:____________________

Endometrial Yes No Details:____________________

Uterine Yes No Details:____________________

Prostrate Yes No Details:____________________

Other: ____________________

Treatment:____________________

Remission:____________________

WEIGHT RELATED INJURIES AND TRAUMA

Yes No Details:____________________

NEUROLOGICAL

Stroke Yes No Details:____________________

Seizure Yes No Details:____________________

Epilepsy Yes No Details:____________________

PSYCHOLOGICAL DISORDERS

Depression Yes No Details:____________________

Bi-Polar Yes No Details:____________________

Anxiety Yes No Details:____________________

EATING DISORDER Yes No Details:____________________

If Yes, have you been seen by a specialist? Yes No

Do you use any of the following medications?

Aspirin Yes No

Non-Steroidal Anti-Inflammatory Drug (NSAID) Yes No

Blood Thinner (Coumadin, Plavix, Lovenox) Yes No

PATIENT NAME:____________________

PLEASE LIST ALL PHYSICIANS UNDER WHOM YOU RECEIVE MEDICAL CARE

	NAME	ADDRESS	PHONE NUMBER
Primary Care Physician			
Cardiologist			
Pulmonologist			
Psychiatrist / Psychologist			
Gynecologist			
Orthopedist			
Other			

PATIENT NAME:____