



**CONTACT PERSONS:**

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know. We will not release any medical information unless you sign a release.

1. NEXT OF KIN

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: (Home) \_\_\_\_\_ (Bus) \_\_\_\_\_ (Cell) \_\_\_\_\_

I authorize Fort Worth Lap-Band to discuss my personal medical information with the person named above. \_\_\_\_\_

2. ADDITIONAL CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: (Home) \_\_\_\_\_ (Bus) \_\_\_\_\_ (Cell) \_\_\_\_\_

I authorize Fort Worth Lap-Band to discuss my personal medical information with the person named above. \_\_\_\_\_

**REFERRAL INFORMATION**

Referring Doctor: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Contact: \_\_\_\_\_

Primary Care Physician if different from referral: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Contact: \_\_\_\_\_

<b>MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING</b>			
<b>Name</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Indications</b>

**Patient Name:** \_\_\_\_\_

<b>PAST SURGICAL HISTORY: PLEASE LIST ALL SURGICAL OPERATIONS</b>			
<b>Procedure</b>	<b>Date</b>	<b>Hospital</b>	<b>Indications</b>

<b>FAMILY MEDICAL HISTORY</b>					
Do you have a family history of any of the following and if so, please indicate:					
	<b>PARENT</b>	<b>SIBLING / CHILD</b>	<b>OTHER RELATIVES (cousins, aunts, grandparents etc)</b>	<b>NO FAMILY HISTORY</b>	<b>DON'T KNOW</b>
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring/sleep apnea					
Asthma					
Allergies					
Hay fever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

**SOCIAL HISTORY**

Do you use tobacco? **YES NO**  
 Number of packs per day \_\_\_\_\_  
 Years of tobacco? \_\_\_\_\_  
 Do you use alcohol? **YES NO**  
 Amount and frequency \_\_\_\_\_  
 Have you ever been treated for depression? **YES NO**  
 Are you currently in treatment? **YES NO**  
 Have you ever been hospitalized for mental illness? **YES NO**  
 If yes, please indicate the name of you physician or therapist: \_\_\_\_\_

**SYSTEM REVIEW: PLEASE CIRCLE ALL THAT APPLY**

**Constitutional**

Fatigue  
Tiredness  
Recent Weight Loss  
Fever  
Night Sweats  
Abnormal Bleeding

**Head and Neck**

Blurred vision  
Double vision  
Loss of vision  
Loss of hearing  
Vertigo  
Runny Nose  
Sneezing  
Loss of smell  
Sinus infection  
Sore throat  
Difficulty Swallowing  
Hoarseness  
Lump in neck  
Pain swallowing  
Sinus Congestion

**Cardiovascular**

Chest pain  
Pain in arm/neck  
Heart attack  
Palpitations  
Heart pounding  
Stroke  
Heart murmur  
Pain in legs  
Cold feet  
Loss of pulses  
Low blood pressure  
High blood pressure  
Abnormal heart beats

**Respiratory**

Shortness of breath  
Asthma  
Wheezing  
Cough  
Bloody Sputum  
Emphysema  
Pneumonia  
Bronchitis  
Difficulty sleeping flat  
Waking at night short of breath

**Gastrointestinal**

Jaundice  
Hepatitis  
Cirrhosis  
Vomiting  
Nausea  
Heartburn  
Abdominal pain  
Diarrhea  
Constipation  
Pain with bowel movements  
Blood in stool  
Hemorrhoids  
Change in stool size  
Irritable bowel  
Colitis

**Genitourinary**

Blood in urine  
Frequent urination  
Leakage of urination  
Pain with urine  
Trouble starting urine  
Kidney stones  
Bladder infection

**Men**

Discharge from penis  
Loss of erection

**Women**

Vaginal Discharge  
Abnormal Vaginal bleeding  
Irregular Periods  
Hysterectomy in last year  
Pap exam w/in last year

**Musculoskeletal**

Pain in joints  
Muscular aches  
Swelling of joints  
Arthritis  
Pain in hips  
Pain in knees  
Pain in ankles  
Pain in feet  
Lower back pain  
Herniated disk  
Sciatica  
Numbness in feet or legs  
Abnormal lumps or masses

**Endocrine**

Hyperthyroid  
Hypothyroid  
Goiter  
Previous radiation  
Diabetes  
Adrenal gland tumor  
Previous steroid use  
Swollen glands

**Skin/Breast**

Skin Cancer  
Abnormal Moles  
Burns  
Rash  
Breast Mass  
Nipple Discharge  
Mammogram w/in last year

**Neurological**

Seizures  
Convulsions  
Fainting  
Vertigo  
Light Headedness  
Falling  
Muscle weakness  
Numbness  
Tremors  
Stroke  
Loss of consciousness

**Psychological**

Depression  
Nervousness  
Anxiety  
Suicidal thoughts  
Suicide attempt  
Schizophrenia  
Anorexia  
Bulimia  
Binge eating  
Counseling  
Hospitalization for emotional problem

**ALLERGIES (including foods, medications, dressings):**    Yes    No

If yes, please give details: \_\_\_\_\_

**Patient name:** \_\_\_\_\_

## OBESITY RELATED MEDICAL HISTORY

Do you have or have you had any of the following illnesses or symptoms?

Heart disease	Yes	No	Year of diagnosis _____
Angina	Yes	No	Year of diagnosis _____
MI (Heart attack)	Yes	No	Year of diagnosis _____
Coronary bypass surgery	Yes	No	Year of surgery _____
Palpitations (abnormal heart beat)	Yes	No	Year of diagnosis _____
Congestive heart failure	Yes	No	Year of diagnosis _____
High blood pressure	Yes	No	Year of diagnosis _____
Elevated Cholesterol	Yes	No	Year of diagnosis _____
Elevated triglycerides	Yes	No	Year of diagnosis _____
Asthma	Yes	No	Year of diagnosis _____
Reflux	Yes	No	Year of diagnosis _____
Heartburn	Yes	No	Year of diagnosis _____
Esophagitis	Yes	No	Year of diagnosis _____
Hiatal Hernia	Yes	No	Year of diagnosis _____
Shortness of breath	Yes	No	

How many blocks can you walk? \_\_\_\_\_

Flights of stairs? \_\_\_\_\_

Sleep Apnea	Yes	No	Year of diagnosis _____
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Do you use CPAP/BiPAP Yes No

Sleep difficulties

Snoring	Yes	No
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Awakening at night	Yes	No
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Daytime drowsiness	Yes	No
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Observed apnea spells	Yes	No
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Morning headaches	Yes	No
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Venous Stasis	Yes	No
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Leg or ankle edema	Yes	No
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Leg ulceration	Yes	No
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Pain of Arthritis	Yes	No
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In ankles	Yes	No
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In knees	Yes	No
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In hips	Yes	No
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Limits ability to walk	Yes	No
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Limits ability to exercise	Yes	No
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Low back pain/Sciatica	Yes	No
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Limits ability to walk	Yes	No
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Limits ability to exercise	Yes	No
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**Patient Name:** \_\_\_\_\_

Diabetes	Yes	No	Year of diagnosis _____
Juvenile onset			
Gestational (pregnancy)			
Adult onset			
Diet controlled	Yes	No	
Oral medications	Yes	No	
Insulin	Yes	No	
Urinary Incontinence	Yes	No	
Leaking urine with cough	Yes	No	
Leaking urine with sneezing	Yes	No	
Leaking urine with straining	Yes	No	
Migraine	Yes	No	
Frequency _____			
Deep Venous Thrombosis	Yes	No	Year of diagnosis _____
Pulmonary embolism	Yes	No	
Abdominal wall hernia	Yes	No	
Incisional	Yes	No	
Umbilical	Yes	No	
Number of hernia repairs _____			
Have you ever had/been?			
Blood transfusions	Yes	No	
Hepatitis	Yes	No	
Exposed to HIV/AIDS	Yes	No	
Abused intravenous drugs	Yes	No	

**PAST MEDICAL HISTORY**

Please list all other medical conditions, illnesses or important information not previously mentioned:

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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# WEIGHT LOSS HISTORY

How Many Years have you been overweight?

\_\_\_\_\_

Previous Weight Loss Surgery Yes No Surgeon: \_\_\_\_\_

Weight Lost: \_\_\_\_\_

## PAST ATTEMPTS

Other weight loss measures (including surgical):

<b>Program</b>	<b>Date</b>	<b>Duration</b>	<b>Dr. Supervised</b>	<b>Weight Lost</b>
Weight Watchers				
Jenny Craig				
NutriSystem				
Gloria Marshall				
Phen-Fen				
Optifast				
Atkins				
Metabolife				
Herbalife				
Grapefruit Diet				
Slim Fast				
Medifast				
Liquid Diets				
Pritikin Diet				

<b>WEIGHT LOSS MEDICATION HISTORY</b>				
<b>Medication</b>	<b>Dates</b>	<b>Duration</b>	<b>Dr. Supervised</b>	<b>Weight Lost</b>
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Phen-Fen				
Redux (Dexfenfluramine)				
Xenical (Orlistat)				

<b>NON DIETARY THERAPIES</b>			
Exercise			
Hypnosis			
Modification Behavior			
Acupuncture			

**How did you first hear about us?**

TV  Radio  Newspaper  Yellow Pages  Friend Other: \_\_\_\_\_

Internet www. \_\_\_\_\_

**Patient Name:** \_\_\_\_\_