

## 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 _____ |
| Do you use CPAP/BiPAP              | Yes   | No |                         |
| Sleep difficulties                 |       |    |                         |
| Snoring                            | Yes   | No |                         |
| Awakening at night                 | Yes   | No |                         |
| Daytime drowsiness                 | Yes   | No |                         |
| Observed apnea spells              | Yes   | No |                         |
| Morning headaches                  | Yes   | No |                         |
| Venous Stasis                      | Yes   | No |                         |
| Leg or ankle edema                 | Yes   | No |                         |
| Leg ulceration                     | Yes   | No |                         |
| Pain of Arthritis                  | Yes   | No |                         |
| In ankles                          | Yes   | No |                         |
| In knees                           | Yes   | No |                         |
| In hips                            | Yes   | No |                         |
| Limits ability to walk             | Yes   | No |                         |
| Limits ability to exercise         | Yes   | No |                         |
| Low back pain/Sciatica             | Yes   | No |                         |
| Limits ability to walk             | Yes   | No |                         |
| Limits ability to exercise         | Yes   | No |                         |

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 signature: \_\_\_\_\_ Date: \_\_\_\_\_