

# Kettering Weight Loss Surgery Patient Profile

## Personal Information

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Ethnic Group    Caucasian                      African American                      Asian  
                         Hispanic                                      American Indian                      Other

(Please make corrections if any of the following information has changed since you sent in your Demographic Form.)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone:    (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Cellular #: \_\_\_\_\_ Beeper #: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Marital Status:            Never Married                      Married                      Divorced  
   Widowed                                      Separated

Spouse's Name: \_\_\_\_\_

## Referral Information

How did you hear about us? Please check all that apply.

Physician                      Other Patient                      Newspaper                      Magazine  
Yellow Pages                      Television                      Our Website                      Internet

Referring Doctor: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

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

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Contact Person(s)

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not update our office.

NEXT OF KIN (NOT LIVING WITH YOU)

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

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

\_\_\_\_\_

Telephone: Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

## Physicians

Primary Care Physician:

Address:

Telephone #

Fax #

Cardiologist:

Address:

Telephone #

Fax #

Psychologist:

Address:

Telephone #

Fax #

Psychiatrist:

Address:

Telephone #

Fax #

Pulmonologist:

Address:

Telephone #

Fax #

Endocrinologist:

Address:

Telephone #

Fax #

Orthopedic Surgeon:

Address:

Telephone #

Fax #

Other:

Address:

Telephone #

Fax #

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Weight and Weight Loss History

Height:        ft. \_\_\_\_\_        in. \_\_\_\_\_        Weight: \_\_\_\_\_

Age of obesity onset:

\_\_\_\_\_ 0-2 years old        \_\_\_\_\_ 12-18 years old        \_\_\_\_\_ Pregnancy  
\_\_\_\_\_ 2-12 years old        \_\_\_\_\_ Young Adult        \_\_\_\_\_ Middle Age

How many years have you been at your present weight? \_\_\_\_\_ Years

Greatest single weight loss: \_\_\_\_\_ pounds

Weight loss was sustained for: \_\_\_\_\_ months

Were there any particular events that lead to significant weight gain?

\_\_\_\_\_ Loss of a loved one        \_\_\_\_\_ Trauma-accident or illness  
\_\_\_\_\_ Pregnancy        \_\_\_\_\_ Loss of employment

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Detailed Diet History

Fill in the dates you participated in the following diet programs, the **pounds lost, pounds regained** and the **time spent** in each program.

| Name of diet program            | Dates Followed/Taken |    | Number of months | Pounds lost | Pounds regained |
|---------------------------------|----------------------|----|------------------|-------------|-----------------|
|                                 | From                 | To |                  |             |                 |
| Acupuncture                     |                      |    |                  |             |                 |
| Weight Watchers                 |                      |    |                  |             |                 |
| Nutrisystem                     |                      |    |                  |             |                 |
| Pritikin                        |                      |    |                  |             |                 |
| Scarsdale                       |                      |    |                  |             |                 |
| Diet Center                     |                      |    |                  |             |                 |
| Jenny Craig                     |                      |    |                  |             |                 |
| Dexatrim                        |                      |    |                  |             |                 |
| Grapefruit Diet                 |                      |    |                  |             |                 |
| Rice                            |                      |    |                  |             |                 |
| Atkins                          |                      |    |                  |             |                 |
| Slim Fast                       |                      |    |                  |             |                 |
| O.A.                            |                      |    |                  |             |                 |
| Herbal Diets                    |                      |    |                  |             |                 |
| Hypnosis                        |                      |    |                  |             |                 |
| Tops                            |                      |    |                  |             |                 |
| Teeth Wiring                    |                      |    |                  |             |                 |
| Calorie Counting                |                      |    |                  |             |                 |
| Richard Simmons                 |                      |    |                  |             |                 |
| Exercising                      |                      |    |                  |             |                 |
| Low Fat                         |                      |    |                  |             |                 |
| Cabbage Diet                    |                      |    |                  |             |                 |
| American Heart Association      |                      |    |                  |             |                 |
| Radar Institute                 |                      |    |                  |             |                 |
| Duke University Programs        |                      |    |                  |             |                 |
| Structure House                 |                      |    |                  |             |                 |
| Inpatient Psychiatric Programs  |                      |    |                  |             |                 |
| Outpatient Psychiatric Programs |                      |    |                  |             |                 |
| Opifast                         |                      |    |                  |             |                 |
| Carefast                        |                      |    |                  |             |                 |
| Medifeast                       |                      |    |                  |             |                 |
| Meridia                         |                      |    |                  |             |                 |
| Zenical                         |                      |    |                  |             |                 |
| Fastin                          |                      |    |                  |             |                 |
| Ionamin                         |                      |    |                  |             |                 |
| Phenteramine/Fenfluramine       |                      |    |                  |             |                 |
| Redux                           |                      |    |                  |             |                 |
| Other:                          |                      |    |                  |             |                 |

Details of any other weight loss measures (including surgical):

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Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

## Surgical History

Please indicate with a check any of the following surgeries you have had and indicate the year of the surgery.

| TYPE OF SURGERY               | HAD SURGERY | YEAR |
|-------------------------------|-------------|------|
| Adenioidectomy                |             |      |
| Angioplasty                   |             |      |
| Ankle Surgery                 |             |      |
| Appendectomy                  |             |      |
| Back Surgery                  |             |      |
| Breast Augmentation           |             |      |
| Breast Reduction              |             |      |
| Breast Biopsy                 |             |      |
| Carpal Tunnel Surgery         |             |      |
| Cesarean Section              |             |      |
| Cholecystectomy (Gallbladder) |             |      |
| Coronary Bypass               |             |      |
| D & C                         |             |      |
| Gastric Bypass                |             |      |
| Hemorrhoidectomy              |             |      |
| Hernia Repair                 |             |      |
| Hysterectomy                  |             |      |
| Knee Surgery                  |             |      |
| Lap Band                      |             |      |
| Lasik                         |             |      |
| Liposuction                   |             |      |
| Lumbar Laminectomy            |             |      |
| Mastectomy                    |             |      |
| Oral Surgery                  |             |      |
| Ovarian Cystectomy            |             |      |
| Panniculectomy                |             |      |
| Pilonidal Cystectomy          |             |      |
| Prostate Surgery              |             |      |
| Tonsilectomy                  |             |      |
| Tubal Litigation              |             |      |
| VBG                           |             |      |
| Wisdom Teeth                  |             |      |

Any problems with anesthesia?

YES \_\_\_\_\_

NO \_\_\_\_\_

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

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

(Please put your first and last name on each page.)

Have you ever had a hernia? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If so, what type? (Check all that apply)

\_\_\_\_\_ Umbilical      \_\_\_\_\_ Hiatal      \_\_\_\_\_ Inguinal (groin)      \_\_\_\_\_ Ventral

Do you currently have a hernia?  
 If so, what type? (Check all that apply)

\_\_\_\_\_ Umbilical      \_\_\_\_\_ Hiatal      \_\_\_\_\_ Inguinal (groin)      \_\_\_\_\_ Ventral

Have you had a previous blood transfusion? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, date \_\_\_\_\_ reason \_\_\_\_\_

Have you had an allergic reaction to tape? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had any food allergies? YES \_\_\_\_\_ NO \_\_\_\_\_

**Allergies to Medication**

| DRUG                   | IF ALLERGIC (PLEASE CHECK) | INDICATE REACTION |
|------------------------|----------------------------|-------------------|
| No Know Drug Allergies |                            |                   |
| Aspirin                |                            |                   |
| Codeine                |                            |                   |
| Demeral                |                            |                   |
| Erythromycin           |                            |                   |
| Iodine                 |                            |                   |
| Keflex                 |                            |                   |
| Morphine               |                            |                   |
| Penicilin              |                            |                   |
| Sulfa                  |                            |                   |
| Tetracycline           |                            |                   |

**Latex Allergy Screening Questionnaire**

Do you have an allergy to any latex products? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you experience local swelling, itching or  
 Dermatitis associated to contact with Latex? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a history of wheel or blister?  
 Formation on contact with latex products? YES \_\_\_\_\_ NO \_\_\_\_\_

Are you allergic to:

|           |           |          |
|-----------|-----------|----------|
| Kiwi      | YES _____ | NO _____ |
| Banana    | YES _____ | NO _____ |
| Avocado   | YES _____ | NO _____ |
| Chestnuts | YES _____ | NO _____ |

Does your occupation involve exposure to NRL?  
 (NATURAL RUBBER LATEX) YES \_\_\_\_\_ NO \_\_\_\_\_

Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

## Personal Medical Information

Have you ever been diagnosed with Cancer

YES \_\_\_\_\_ NO \_\_\_\_\_

If so, check all that apply

Breast                       Endometrial                       Prostate                       Colon  
 Thyroid                       Skin                       Blood                       Other

Year Diagnosed \_\_\_\_\_

Cancer Free for \_\_\_\_\_ years

Treatment, check all that apply

Surgery                       Chemotherapy                       Radiation                       Medication

Do you wear glasses? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you wear contacts? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have regular dental check-ups? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had previous dental surgery? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you wear dentures? YES \_\_\_\_\_ NO \_\_\_\_\_

Upper? YES \_\_\_\_\_ NO \_\_\_\_\_

Lower? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have missing teeth? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, how many? \_\_\_\_\_

Have you ever had an:

EKG YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Stress Test YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Echocardiogram YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Cardiac Catheterization YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

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

(Please put your first and last name on each page.)

## Personal Medical History

|                                   | Have you been diagnosed with or do you suffer from each of the following? | Are you currently being treated for it? | Are you currently taking medication for it? |
|-----------------------------------|---|---|---|
|                                   | <i>Check if yes</i>   | <i>Check if yes</i>                     | <i>Check if yes</i>                         |
| <b>Head and Neck</b>              |   |   |   |
| Glaucoma                          |   |   |   |
| Cataracts                         |   |   |   |
| Hearing Loss                      |   |   |   |
| Vertigo                           |   |   |   |
| Tinnitus                          |   |   |   |
| Migraine Headaches                |   |   |   |
| <b>Cardiovascular</b>             |   |   |   |
| High Blood Pressure               |   |   |   |
| Angina                            |   |   |   |
| Pulmonary Hypertension            |   |   |   |
| Chest Pain with effort            |   |   |   |
| High Cholesterol                  |   |   |   |
| High Blood Fats (Lipids)          |   |   |   |
| Irregular Heart Beat              |   |   |   |
| Heart Palpitations                |   |   |   |
| Congestive Heart Failure          |   |   |   |
| Leg Ulcers                        |   |   |   |
| Varicose Veins                    |   |   |   |
| Ankle Swelling                    |   |   |   |
| <b>Respiratory</b>                |   |   |   |
| Sleep Apnea                       |   |   |   |
| Shortness of Breath at Rest       |   |   |   |
| Shortness of Breath with Activity |   |   |   |
| Emphysema                         |   |   |   |
| Chronic Cough                     |   |   |   |
| Wheezing                          |   |   |   |
| Asthma as a child                 |   |   |   |
| Asthma as an adult                |   |   |   |
| <b>Musculo-skeletal</b>           |   |   |   |
| Arthritis                         |   |   |   |
| Ankle pain                        |   |   |   |
| Osteoarthritis                    |   |   |   |
| Rheumatoid Arthritis              |   |   |   |
| Back Pain                         |   |   |   |
| Knee Pain                         |   |   |   |
| Plantar Fascitis                  |   |   |   |
| Heel Spurs                        |   |   |   |

Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

|                         | Have you been diagnosed with or do you suffer from each of the following? | Are you currently being treated for it? | Are you currently taking medication for it? |
|-------------------------|---|---|---|
|                         | <i>Check if yes</i>   | <i>Check if yes</i>                     | <i>Check if yes</i>                         |
| <b>Gastrointestinal</b> |   |   |   |
| GERD                    |   |   |   |
| Heartburn               |   |   |   |
| Stomach Ulcer           |   |   |   |
| Duodenal Ulcer          |   |   |   |
| Constipation            |   |   |   |

Number of Bowel movements per day \_\_\_\_\_ Number Per Week \_\_\_\_\_

Days Between bowel movements \_\_\_\_\_

|          |  |  |  |
|----------|--|--|--|
| Vomiting |  |  |  |
|----------|--|--|--|

\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_ Occasionally

If everyday, how many times per day \_\_\_\_\_

|          |  |  |  |
|----------|--|--|--|
| Diarrhea |  |  |  |
|----------|--|--|--|

\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_ Occasionally

If everyday, how many times per day \_\_\_\_\_

| <b>Gallbladder Disease</b>             |  |  |  |
|--|--|--|--|
| Gall Stones                            |  |  |  |
| Inflammation/Infection                 |  |  |  |
| <b>Genito-urinary</b>                  |  |  |  |
| Urinary Frequency (over 6 x per day)   |  |  |  |
| Urinary Retention                      |  |  |  |
| Recurrent Urinary Tract Infection      |  |  |  |
| Kidney Stones                          |  |  |  |
| Kidney Disease                         |  |  |  |
| Renal Failure                          |  |  |  |
| Gout                                   |  |  |  |
| Stress Incontinence (leakage of urine) |  |  |  |

\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_ Occasionally

If everyday, how many times per day \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

|                                       | Have you been diagnosed with or do you suffer from each of the following? | Are you currently being treated for it? | Are you currently taking medication for it? |
|---------------------------------------|---|---|---|
|                                       | <i>Check if yes</i>   | <i>Check if yes</i>                     | <i>Check if yes</i>                         |
| <b>OB/GYN</b>                         |   |   |   |
| Irregular periods                     |   |   |   |
| Excessively Heavy Periods             |   |   |   |
| Excessively Painful Periods           |   |   |   |
| Difficulty in Conceiving              |   |   |   |
| Infertility-with or without treatment |   |   |   |
| <b>Endocrinology</b>                  |   |   |   |
| Diabetes                              |   |   |   |
| Hypothyroid                           |   |   |   |
| Hyperthyroid                          |   |   |   |
| Goiter                                |   |   |   |
| Graves Disease                        |   |   |   |
| <b>Neurological</b>                   |   |   |   |
| Numbness/Tingling-hands               |   |   |   |
| --Feet                                |   |   |   |
| --Front or side of thigh              |   |   |   |
| Seizures                              |   |   |   |
| Weakness-Hands                        |   |   |   |
| Weakness-Feet                         |   |   |   |
| Epilepsy                              |   |   |   |
| Pseudotumor                           |   |   |   |
| <b>Skin</b>                           |   |   |   |
| Dermatitis                            |   |   |   |
| Urticaria                             |   |   |   |
| Rashes                                |   |   |   |
| Open Sores                            |   |   |   |
| <b>Hematology</b>                     |   |   |   |
| Anemia                                |   |   |   |
| Heparin Exposure                      |   |   |   |
|                                       | When? _____   | Why? _____                              |   |
| Coumidin Use                          |   |   |   |
|                                       | When? _____   | Why? _____                              |   |
| Iron Supplements                      |   |   |   |
|                                       | When? _____   | Why? _____                              |   |

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

|                           | Have you been diagnosed with or do you suffer from each of the following? | Are you currently being treated for it? | Are you currently taking medication for it? |
|---------------------------|---|---|---|
|                           | <i>Check if yes</i>   | <i>Check if yes</i>                     | <i>Check if yes</i>                         |
| <b>Psychological</b>      |   |   |   |
| Depression                |   |   |   |
| Bi-Polar                  |   |   |   |
| Anxiety                   |   |   |   |
| Schizophrenia             |   |   |   |
| Anorexia                  |   |   |   |
| Bulimia                   |   |   |   |
| Suicide Attempt           |   |   |   |
| <b>Infectious Disease</b> |   |   |   |
| HIV Positive              |   |   |   |
| Staph Infection           |   |   |   |
| Liver Disease             |   |   |   |
| Hepatitis A               |   |   |   |
| Hepatitis B               |   |   |   |
| Hepatitis C               |   |   |   |

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**DIABETES**-If you have been diagnosed with or treated for diabetes please complete the following section

Juvenile Onset YES \_\_\_\_\_ NO \_\_\_\_\_ Year Diagnosed \_\_\_\_\_

Adult Onset YES \_\_\_\_\_ NO \_\_\_\_\_ Year Diagnosed \_\_\_\_\_

Current form of Control:

Diet Control Only YES \_\_\_\_\_ NO \_\_\_\_\_ As of (year) \_\_\_\_\_

Oral Hypoglycemics YES \_\_\_\_\_ NO \_\_\_\_\_ As of (year) \_\_\_\_\_

Insulin YES \_\_\_\_\_ NO \_\_\_\_\_ As of (year) \_\_\_\_\_

Number of injections per day \_\_\_\_\_

Do you have glycosylated hemoglobin (HBA1C) levels tested YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what is your level (if you know) \_\_\_\_\_

**SLEEP APNEA**-Please complete the following even if you have not been diagnosed with sleep apnea

Do you use C-Pap? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you use Bi-Pap? YES \_\_\_\_\_ NO \_\_\_\_\_

Please mark, which symptoms apply

Snorting or gasping YES \_\_\_\_\_ NO \_\_\_\_\_

Loud snoring YES \_\_\_\_\_ NO \_\_\_\_\_

Breathing stops, choke or struggle for breath YES \_\_\_\_\_ NO \_\_\_\_\_

Frequent awakenings YES \_\_\_\_\_ NO \_\_\_\_\_

Tossing, turning or thrashing YES \_\_\_\_\_ NO \_\_\_\_\_

Difficulty falling asleep YES \_\_\_\_\_ NO \_\_\_\_\_

Morning headaches YES \_\_\_\_\_ NO \_\_\_\_\_

Night sweats YES \_\_\_\_\_ NO \_\_\_\_\_

More than three pillows used under head YES \_\_\_\_\_ NO \_\_\_\_\_

Falling asleep when at work or school YES \_\_\_\_\_ NO \_\_\_\_\_

Falling asleep when driving YES \_\_\_\_\_ NO \_\_\_\_\_

Excessive sleepiness during the day YES \_\_\_\_\_ NO \_\_\_\_\_

Awaken feeling paralyzed, unable to move for short periods YES \_\_\_\_\_ NO \_\_\_\_\_

How well rested do you feel after a full nights sleep?

\_\_\_\_\_ Not at all \_\_\_\_\_ Somewhat \_\_\_\_\_ Well Rested

Do you feel more comfortable sleeping in an upright position? YES \_\_\_\_\_ NO \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**GERD-Please complete the following even if you have not been diagnosed with GERD**

How often do you have reflux during the day?

Many Times Per Day\_\_\_\_ Everyday\_\_\_\_ Most Days\_\_\_\_ Most Weeks\_\_\_\_ Occasionally\_\_\_\_

Do you suffer from heartburn/indigestion during the night? If so how often?

Many Times Per Day\_\_\_\_ Everyday\_\_\_\_ Most Days\_\_\_\_ Most Weeks\_\_\_\_ Occasionally\_\_\_\_

Does food or fluid reflux in the mouth? YES\_\_\_\_\_ NO\_\_\_\_\_

Do you vomit with reflux? YES\_\_\_\_\_ NO\_\_\_\_\_

Treatments you may use for reflux, heartburn or indigestion, either prescribed or over the counter

Check all those that apply

\_\_\_\_\_ Zantac                  \_\_\_\_\_ Tagamed                  \_\_\_\_\_ Pepcid                  \_\_\_\_\_ Prevacid  
\_\_\_\_\_ Nexium                  \_\_\_\_\_ Prilosec                  \_\_\_\_\_ Surgery

Please list any current medical conditions or concerns not covered above.

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Details of any other hospitalizations for medical problems.

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## Social Profile

### Family Structure

Do you have any children? YES \_\_\_\_\_ NO \_\_\_\_\_

How many children/grandchildren in each of the following age groups do you have living with you:

Include nieces, nephews or other dependants

\_\_\_\_\_ 0-2 years old                      \_\_\_\_\_ 8-12 years old                      \_\_\_\_\_ 18-25 years old  
\_\_\_\_\_ 2-8 years old                      \_\_\_\_\_ 12-18 years old                      \_\_\_\_\_ over 25 years old

Do you have a support person friend? YES \_\_\_\_\_ NO \_\_\_\_\_  
Do they live with you? YES \_\_\_\_\_ NO \_\_\_\_\_

Combined Household Income  
\_\_\_\_\_ Less than \$20,000                      \_\_\_\_\_ \$40,000-\$59,999                      \_\_\_\_\_ \$80,000-\$99,999  
\_\_\_\_\_ \$20,000-\$39,999                      \_\_\_\_\_ \$60,000-\$79,999                      \_\_\_\_\_ \$100,000 or more

### Current Employment

Occupation \_\_\_\_\_

Are you currently employed? YES \_\_\_\_\_ NO \_\_\_\_\_

Employer \_\_\_\_\_

Approximate Income  
\_\_\_\_\_ Less than \$20,000                      \_\_\_\_\_ \$40,000-\$59,999                      \_\_\_\_\_ \$80,000-\$99,999  
\_\_\_\_\_ \$20,000-\$39,999                      \_\_\_\_\_ \$60,000-\$79,999                      \_\_\_\_\_ \$100,000 or more

If employed, please state what level of activity your job involves:  
\_\_\_\_\_ Little (sedentary job)                      \_\_\_\_\_ Moderately active                      \_\_\_\_\_ Very active

Do you enjoy your work? YES \_\_\_\_\_ NO \_\_\_\_\_

If you are unemployed, how long? \_\_\_\_\_  
What is the reason? (Check one)  
\_\_\_\_\_ Physically unable to work                      \_\_\_\_\_ emotionally unable to work  
\_\_\_\_\_ Lack of available jobs in the field                      \_\_\_\_\_ Appearance inappropriate for position sought  
\_\_\_\_\_ Lack of skills

Are you currently disabled or on disability? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, how long? \_\_\_\_\_

Education  
\_\_\_\_\_ 8<sup>th</sup> grade or less                      \_\_\_\_\_ High school graduate                      \_\_\_\_\_ College graduate  
\_\_\_\_\_ some high school                      \_\_\_\_\_ Some college                      \_\_\_\_\_ Any post graduate work

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**Social Data**

Do you drink coffee? YES \_\_\_\_\_ NO \_\_\_\_\_ How many cups per day \_\_\_\_\_

Do you smoke cigarettes? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, how Long \_\_\_\_\_

Do you smoke cigars? YES \_\_\_\_\_ NO \_\_\_\_\_ How many per day \_\_\_\_\_

How long ago did you stop smoking? \_\_\_\_\_ Years \_\_\_\_\_ Months

Do you drink alcohol? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, how often?  
\_\_\_\_\_ Everyday    \_\_\_\_\_ Most Days    \_\_\_\_\_ Most Weeks    \_\_\_\_\_ Most Months  
\_\_\_\_\_ Rarely

If yes, when drinking do you tend to binge to excess? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a history of drug or alcohol addiction? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, how long have you been alcohol or drug free \_\_\_\_\_ Months

What treatment did you receive, check all that apply

\_\_\_\_\_ Residential treatment    \_\_\_\_\_ Counseling    \_\_\_\_\_ Support groups such as AA

## Family Medical History

FATHER:

Please check one:  Living  Deceased | If Deceased: Age \_\_\_\_\_

Cause of death:  Cancer  Accident  Age Related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES \_\_\_\_\_ NO \_\_\_\_\_

Heart Disease YES \_\_\_\_\_ NO \_\_\_\_\_

Hypertension YES \_\_\_\_\_ NO \_\_\_\_\_

Diabetes YES \_\_\_\_\_ NO \_\_\_\_\_

History of Cancer YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, check type:  Breast  Endometrial  Prostate  
 Colon  Thyroid  Skin  Blood  Other

MOTHER:

Please check one:  Living  Deceased | If Deceased: Age \_\_\_\_\_

Cause of death:  Cancer  Accident  Age Related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES \_\_\_\_\_ NO \_\_\_\_\_

Heart Disease YES \_\_\_\_\_ NO \_\_\_\_\_

Hypertension YES \_\_\_\_\_ NO \_\_\_\_\_

Diabetes YES \_\_\_\_\_ NO \_\_\_\_\_

History of Cancer YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, check type:  Breast  Endometrial  Prostate  
 Colon  Thyroid  Skin  Blood  Other

SISTER:

Please check one:  Living  Deceased | If Deceased: Age \_\_\_\_\_

Cause of death:  Cancer  Accident  Age Related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES \_\_\_\_\_ NO \_\_\_\_\_

Heart Disease YES \_\_\_\_\_ NO \_\_\_\_\_

Hypertension YES \_\_\_\_\_ NO \_\_\_\_\_

Diabetes YES \_\_\_\_\_ NO \_\_\_\_\_

History of Cancer YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, check type:  Breast  Endometrial  Prostate  
 Colon  Thyroid  Skin  Blood  Other

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**BROTHER:**

Please check one:  Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age Related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO

Heart Disease YES  NO

Hypertension YES  NO

Diabetes YES  NO

History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  
 Colon  Thyroid  Skin  Blood  Other

**SPOUSE:**

History of Obesity YES  NO  Not Applicable

**CHILDREN:**

History of Obesity YES  NO  Not Applicable

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I ATTENDED INFOR SESSION ON \_\_\_\_\_, 20\_\_.

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PATIENT'S SIGNATURE

DATE

**Authorization for Release of Insurance**

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

I am interested in having surgery with Kettering Weight Loss Center. Therefore, I would like you to release any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Kettering Weight Loss Center of the reasonable and customary reimbursements for my surgical procedure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

**Release for Use of Photograph**

I, \_\_\_\_\_ do hereby authorize the staff of Kettering Weight Loss Center absolute permission to utilize any photographs take of me pre-operatively, intra-operatively or post –operatively in reference to my Roux en-Y Gastric Bypass or Laparoscopic Adjustable Gastric Band, to use, re-use, publish or republish in whole or in part, individually or in conjunction with others, in any medium and for any purpose whatsoever, including (not limited to) illustration, promotion and/or advertising and trade.

I also release and discharge Kettering Medical Weight Loss from any and all claims and demands arising from or in connection with the use of my photographs, including claims for libel.

I have read and fully understand the intent and purpose of this release and I am signing it without reservation.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

