SWEDISH

Swedish Weight Loss Services

Patient History Form

What program are you considering?

☐ Non-Surgical Weight Management ☐ Bariatric Surgery

First Name: _____ MI:_____ Last Name:_____

Date of Birth:_____ Phone:_____ Employer:_____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other Ethnicity: _____

Emergency Contact (Please Print)**:**

First Name: _____ Last Name: _____

Relationship To You: _____ Phone: _____

Primary Care Physician:

Physician Name: _____ Phone: _____

Clinic Name: _____ Fax: _____

FAMILY HISTORY			Family Member
☐ Yes	☐ No	Alcoholism	_____
☐ Yes	☐ No	Lung disease / Asthma	_____
☐ Yes	☐ No	Bleeding disorder	_____
☐ Yes	☐ No	Diabetes Mellitus	_____
☐ Yes	☐ No	Heart disease	_____
☐ Yes	☐ No	High blood pressure	_____
☐ Yes	☐ No	Kidney disease	_____
☐ Yes	☐ No	Liver disease	_____
☐ Yes	☐ No	Malignant Hyperthermia	_____
☐ Yes	☐ No	Mental illness	_____
☐ Yes	☐ No	Obesity	_____
☐ Yes	☐ No	Cancer	_____
☐ Yes	☐ No	Other:_____	_____

PATIENT MEDICAL HISTORY / REVIEW OF SYSTEMS

Constitutional

Fevers	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Chronic fatigue	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
History of MRSA	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Bladder / Kidney

Loss of bladder control	☐ Yes	☐ No
Kidney insufficiency	☐ Yes	☐ No
Kidney failure	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No

Blood

Anemia	☐ Yes	☐ No
Blood clot in leg	☐ Yes	☐ No
Blood clot in lung	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Clotting disorder	☐ Yes	☐ No
HIV	☐ Yes	☐ No

Head / Neck

Vision problems	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No

Musculoskeletal

Arthritis	☐ Yes	☐ No
Joint / Back pain: _____	☐ Yes	☐ No
Plantar fasciitis	☐ Yes	☐ No
Nerve injury	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No

Cardiovascular

Heart attack	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Rheumatic Fever/Valve damage	☐ Yes	☐ No
Rhythm disturbance/Palpitations	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
High cholesterol/triglycerides	☐ Yes	☐ No

Skin

Rashes under skin folds	☐ Yes	☐ No
Poor wound healing	☐ Yes	☐ No

Other medical problems? (please list):

Gastrointestinal

Heartburn / Acid reflux	☐ Yes	☐ No
Hiatal hernia	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No
Cirrhosis / Hepatitis / Jaundice	☐ Yes	☐ No
Current gallbladder problems	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Colonoscopy up-to-date?	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Oxygen dependence	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No

Endocrine

Hypothyroid	☐ Yes	☐ No
Hyperthyroid	☐ Yes	☐ No
Diabetes: Type1 Type2 Gest	☐ Yes	☐ No
Date diagnosed:____ Insulin?	☐ Yes	☐ No
Prediabetes	☐ Yes	☐ No
Gout	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Migraines / Headaches	☐ Yes	☐ No

Gynecological

Pregnant or suspect pregnancy?	☐ Yes	☐ No
Are you using birth control?	☐ Yes	☐ No
Type(circle): Oral IUD Implant Injection		
How many pregnancies have you had?_____		
How many live births have you had?_____		
Plan to have more children?	☐ Yes	☐ No
Do you have PCOS?	☐ Yes	☐ No
Are you post-menopausal?	☐ Yes	☐ No
On hormone replacement meds?	☐ Yes	☐ No
Pap smear up-to-date?	☐ Yes	☐ No
Breast exam up-to-date?	☐ Yes	☐ No

SURGICAL HISTORY

Month / Year

☐ Yes ☐ No	Heart bypass / Valve replacement	_____
☐ Yes ☐ No	Pacemaker	_____
☐ Yes ☐ No	Gallbladder ☐ Open ☐ Lap	_____
☐ Yes ☐ No	Appendectomy	_____
☐ Yes ☐ No	Hysterectomy ☐ Abdominal ☐ Vaginal	_____
☐ Yes ☐ No	Cesarean section	_____
☐ Yes ☐ No	Tubal ligation	_____
☐ Yes ☐ No	Hernia repair Location: _____	_____
☐ Yes ☐ No	Transplant Type: _____	_____
☐ Yes ☐ No	Joint replacement	_____
☐ Yes ☐ No	Knee surgery	_____
☐ Yes ☐ No	Back surgery	_____
☐ Yes ☐ No	Other: _____	_____

BARIATRIC / GASTRIC HISTORY

Month / Year

☐ Yes ☐ No	Roux-en-Y Gastric Bypass (RNY)	_____
☐ Yes ☐ No	Vertical Sleeve Gastrectomy (VSG)	_____
☐ Yes ☐ No	Adjustable Gastric Band (LAGB)	_____
☐ Yes ☐ No	Duodenal switch	_____
☐ Yes ☐ No	Gastric balloon	_____
☐ Yes ☐ No	PEG tube insertion	_____
☐ Yes ☐ No	Nissen fundoplication	_____
☐ Yes ☐ No	Stomach stapling	_____
☐ Yes ☐ No	Other stomach surgery / procedure	_____

SOCIAL HISTORY

Current tobacco Use ☐ Yes ☐ No

Previous tobacco Use ☐ Yes ☐ No

Quit date: _____

Do you vape or chew? ☐ Yes ☐ No

Do you drink caffeinated beverages? ☐ Yes ☐ No

How much? _____

Do you drink carbonated drinks? ☐ Yes ☐ No

How much? _____

Do you use cannabis? ☐ Yes ☐ No

Do you use street drugs? ☐ Yes ☐ No

Substance: _____

Do you consume alcohol? ☐ Yes ☐ No

How much? _____

Has alcohol intake ever been a concern for you or those around you? ☐ Yes ☐ No

MEDICATIONS / ALLERGIES

It is important that we know what medications you are currently taking. Please help us by providing accurate, detailed information. **This includes vitamins, minerals and herbal supplements as well as any over the counter (OTC) medications (e.g. Tylenol, ibuprofen).**

Please list all medication allergies:_____

_____

Medication	Dose	Frequency

SLEEP APNEA QUESTIONNAIRE

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No Date:_____ Where:_____

How many hours do you sleep per night? _____ Do you have an oral appliance? ☐ Yes ☐ No

Do you have a CPAP/BiPAP machine? ☐ Yes ☐ No Do you use it nightly? ☐ Yes ☐ No

If you have <u>not</u> been diagnosed with sleep apnea, please answer the questions below:

☐ Yes ☐ No Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

☐ Yes ☐ No Do you often feel tired, fatigued or sleepy during the daytime?

☐ Yes ☐ No Has anyone ever observed you stop breathing during your sleep?

☐ Yes ☐ No Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No Is your BMI greater than 35kg/m^2?

☐ Yes ☐ No Are you over the age of 50 years old?

☐ Yes ☐ No Is your neck circumference greater than 16 inches?

BEHAVIORAL HEALTH

Anxiety	☐ Yes ☐ No	History of / current alcoholism	☐ Yes ☐ No
Depression	☐ Yes ☐ No	History of / current drug addiction	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Have you been in a drug/alcohol rehab?	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Date: _____	
Binge eating disorder	☐ Yes ☐ No	Other psychiatric problems: _____	
Bipolar disorder	☐ Yes ☐ No	Previous suicide attempts	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No	Have you been physically abused?	☐ Yes ☐ No
History of cutting	☐ Yes ☐ No	Have you been sexually abused?	☐ Yes ☐ No

Do you see a psychiatrist/psychologist/counselor? ☐ Yes ☐ No If Yes, provide name & contact number:

_____

Have you ever been hospitalized in a psychiatric ward? ☐ Yes ☐ No If Yes, dates and location:

_____

Have you ever taken medications for psychiatric problems or depression? ☐ Yes ☐ No

If Yes, name/side effects/duration:_____

Subjective Happiness Scale (SHS; Lyubomirsky & Lepper, 1999)

For each of the following statements and/or questions, please circle the point on the scale that you feel is most appropriate in describing you:

1. In general, I consider myself: (not a very happy person) 1 2 3 4 5 6 7 (a very happy person)
2. Compared to most of my peers, I consider myself: (less happy) 1 2 3 4 5 6 7 (more happy)
3. Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extend does this characterization describe you?
   (not at all) 1 2 3 4 5 6 7 (a great deal)
4. Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterization describe you?
   (not at all) 1 2 3 4 5 6 7 (a great deal)

Please rate the following on a scale of 1 to 5: (1 = Least Satisfied; 5 = Very Satisfied)

Relationship (Single / Partner / Married / Divorced):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Current job:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Overall satisfaction with self:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

WEIGHT LOSS HISTORY: HABITS / WEIGHT LOSS ATTEMPTS / EXERCISE

From what age have you been overweight / obese? _____ Current weight: _____lbs.
Healthiest weight: _____lbs. Highest Adult weight: _____lbs. Lowest Adult weight:_____ lbs.
Maximum weight loss at any time_____ lbs. How was this achieved? _____
Have you ever taken medications for weight loss? ☐ Yes ☐ No
If Yes, which medications? _____

Which diets have you attempted, either on your own or supervised?

☐ 30/10	☐ 20/20 Lifestyle	☐ Atkins
☐ Calorie counting	☐ High protein / Low carb	☐ Jenny Craig
☐ Ketogenic	☐ Low fat	☐ Nutrisystem
☐ OptiFast / MediFast	☐ Physician supervised	☐ SlimFast
☐ South Beach	☐ Weight Watchers	☐ Whole30

Do you eat while: ☐ Watching TV ☐ Using Computer / Phone ☐ In Bed ☐ In Car

Which eating habits do you identify with?

		☐ Nighttime eating	☐ Late night eating
☐ Scheduled meals	☐ Not set schedule	☐ Overeating	☐ Eating when bored
☐ Only when hungry	☐ Skipping meals	☐ Rapid eating	☐ Eating as a reward
☐ Cleaning plate	☐ Grazing	☐ Large portions	☐ Inability to feel full

How often in a week do you eat:
Fast Food: _____ At a Restaurant: _____ Takeout / Delivery: _____
Homemade Meals: _____ Junk Food: _____

Describe your pace of eating: ☐ Slow ☐ Average ☐ Fast

During the last 3 months have you had any episodes of excessive overeating?
(i.e. significantly more than what most people would eat in a similar period.) ☐ Yes ☐ No
If Yes, does excessive overeating cause you to be distressed? ☐ Yes ☐ No
Are there medications you feel contribute to your weight? ☐ Yes ☐ No
If Yes, please list: _____

Have you ever used any of the following to control your weight and did you get treatment?
☐ Consuming large portions followed by vomiting Date: _____ Treatment: ☐ Yes ☐ No
☐ Consuming large portions followed by restricting food Date: _____ Treatment: ☐ Yes ☐ No
☐ Laxatives Date: _____ Treatment: ☐ Yes ☐ No
☐ Diuretics Date: _____ Treatment: ☐ Yes ☐ No
☐ Vomiting Date: _____ Treatment: ☐ Yes ☐ No

Do you have food allergies? ☐ Yes ☐ No Do you have food intolerances? ☐ Yes ☐ No
If Yes, list food and reaction: _____

_____

Describe your **current** activity level (please give examples of activity):

☐ Restricted (wheelchair or bed bound)

☐ Sedentary (e.g. desk job, light housecleaning)

☐ Low Active (90 – 120 minutes each week) Example: _____

☐ Active (121 – 150 minutes each week) Example: _____

☐ Very Active (greater than 150 minutes per week) Example: _____

Why do you want to lose weight? _____

_____

_____

What behaviors do you feel you will need to change? _____

_____

Do you have a Support Person that is encouraging of this journey? _____

What are your weight loss goals and expectations? (e.g. pounds to lose, time frame) _____

_____

Is there anything else you would like to share? _____

_____

Patient Signature: _____ Date:_____

By signing above, you agree that all information provided is accurate to the best of your knowledge