



**ADIRONDACK MEDICAL CENTER**  
**Weight Management Program**  
 A Comprehensive Program for Weight Control and Obesity Prevention

**Medical History**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

**PAST MEDICAL HISTORY**

List all operations/surgeries that you have had.

1 _____ date _____	5 _____ date _____
2 _____ date _____	6 _____ date _____
3 _____ date _____	7 _____ date _____
4 _____ date _____	8 _____ date _____

**Have you been diagnosed with MRSA? YES or NO**

**If yes – when** \_\_\_\_\_

List all Hospitalizations (other than surgeries) and the reasons

1 _____ date _____	5 _____ date _____
2 _____ date _____	6 _____ date _____
3 _____ date _____	7 _____ date _____
4 _____ date _____	8 _____ date _____

Do you have any of the following medical problems?

1 Heart Disease	year _____	6 Arthritis	year _____
2 High Blood Pressure	year _____	7 Sugar or Diabetes	year _____
3 Difficulty holding urine	year _____	8 Sleep Apnea	year _____
4 Heartburn/stomach problems	year _____	9 High Cholesterol	year _____
5 Swelling in feet or legs	year _____	10 Any other medical problems	
Other _____	year _____	Other _____	
Other _____	year _____	Other _____	

List your history of any broken bones or other injuries.

1 _____ date _____	5 _____ date _____
2 _____ date _____	6 _____ date _____
3 _____ date _____	7 _____ date _____
4 _____ date _____	8 _____ date _____

List your allergies.

1 _____	reaction _____
2 _____	reaction _____
3 _____	reaction _____
4 _____	reaction _____

**Do you have an allergy to Latex? YES or NO**

Please provide a list of the health care providers caring for you, include addresses

Primary Care Provider \_\_\_\_\_  
 Pulmonologist \_\_\_\_\_  
 Cardiologist \_\_\_\_\_  
 Gastroenterologist \_\_\_\_\_  
 Orthopedist \_\_\_\_\_  
 Neurologist \_\_\_\_\_  
 Psychiatrist \_\_\_\_\_  
 Other \_\_\_\_\_

**SOCIAL HISTORY**

What is your job? \_\_\_\_\_ Spouse name/occupation \_\_\_\_\_  
 Number of children \_\_\_\_\_ Do you smoke/chew tobacco? \_\_\_\_\_  
 How many years have you smoked? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
 When was your last drink of alcohol? \_\_\_\_\_ What did you drink? \_\_\_\_\_  
 How much did you drink? \_\_\_\_\_ Do you smoke pot? \_\_\_\_\_  
 Do you use other drugs such as crack or cocaine? \_\_\_\_\_  
 Are you on disability? \_\_\_\_\_ Reason? \_\_\_\_\_  
 How long on disability? \_\_\_\_\_

**FAMILY HISTORY**

Relationship	AGE	Health,good,fair,poor	If deceased,cause	Age died
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

Which blood relatives have a history of: (write in the person with the problem: mother, father, which side of family i.e. maternal or mothers, paternal or fathers, etc...)

Stroke\_\_\_\_\_ Cancer\_\_\_\_\_

High Blood Pressure\_\_\_\_\_ Tuberculosis\_\_\_\_\_

Diabetes\_\_\_\_\_ Bleeding Disorder\_\_\_\_\_

Heart Disease\_\_\_\_\_ Problems with anesthesia\_\_\_\_\_

Severe obesity \_\_\_\_\_ Overweight (20-99 lbs)\_\_\_\_\_

Other\_\_\_\_\_

Please answer the following questions to the best of your ability

Neurological

Have you ever fainted? Yes No                      Had a convulsion? Yes No

Do you have problems

With your vision?                      Yes No                      Ringing in the ears? Yes No

Severe headaches?                      Yes No                      Do the headaches wake you up? Yes No

Pain on one side of the head? Yes No                      Weakness arms/legs?                      Yes No

Heart and Lungs

Have you had shortness of breath

    Doing normal work                      Yes No                      climbing stairs                      Yes No

    That wakes you up at night                      Yes No                      accompanied by wheezing                      Yes No

Do you have a chronic cough?                      Yes No                      cough up phlegm                      Yes No

How many pillows do you need to sleep?\_\_\_\_\_

Do you snore heavily or stop breathing while asleep?                      Yes No

Do you wake yourself snoring?                      Yes No

Do you wake up with a headache?                      Yes No

Have you had chest pain or tightness:

    When exerting yourself                      Yes No                      When excited or upset?                      Yes No

    After a heavy meal                      Yes No

Does the chest pain

    Go to the arm, neck, or back                      Yes No                      Occur only at rest                      Yes No

    Disappear if you rest                      Yes No                      Do you have palpitations                      Yes No

Phlebitis/inflamed leg veins                      Yes No                      Do you have ankle swelling                      Yes No

Varicose veins                      Yes No

PSYCHIATRIC

Do you have a history of psychiatric illness?                      Yes No

Depression?                      Yes No

Obsessive compulsive disorder?                      Yes No

Bipolar or manic depression?                      Yes No

Have you been in the hospital for mental illness? Yes No

Hospital Name: \_\_\_\_\_ Date: \_\_\_\_\_

Hospital Name: \_\_\_\_\_ Date: \_\_\_\_\_

Past medications for mental illness: \_\_\_\_\_

Have you ever been emotionally abused? Yes No Physically abused? Yes No

Sexually abused? Yes No

**GASTROINTESTINAL**

Do you have pain in the stomach

During or after meals Yes No Brought on by fried/greasy foods Yes No

Does it wake you at night Yes No Relieved by eating Yes No

Gets better with antacids Yes No Relieved by bowel movement Yes No

Do you get belly cramps Yes No

Do you get diarrhea? Yes No How often? \_\_\_\_\_ Do you get constipation Yes No

Do you have pain during or after bowel movement? Yes No

Do you have mucous or blood in stool? Yes No

**GENITOURINARY**

Have you had burning when urinating? Yes No

Loss of control of bladder? Yes No

Blood in urine? Yes No

Trouble starting to urinate? Yes No

Get up at night to urinate? Yes No

Passed a kidney stone? Yes No

**WOMEN**

Do you have monthly periods Yes No

Irregular Heavy Painful

Date of last period \_\_\_\_\_

Bleeding between periods Yes No

Last PAP test \_\_\_\_\_ Last Mammo \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_

C sections \_\_\_\_\_ Still births \_\_\_\_\_ premature births \_\_\_\_\_

Complications \_\_\_\_\_

Birth control used \_\_\_\_\_

**MEN**

Have you had a hernia Yes No

Prostate problems Yes No

Trouble with erections Yes No

Other \_\_\_\_\_

**MUSCULOSKELETAL**

Do you have pain in calves while walking? Yes No Cramps in legs at night? Yes No

Pain in big toe? Yes No Difficulty walking? Yes No

Do you have back problems? Describe \_\_\_\_\_ Do you have pain in joints Yes No

Knees Yes No

Hips Yes No

Legs Yes No

Feet Yes No

Ankles Yes No

**ENDOCRINE**

Do you have diabetes?            Yes No  
Thyroid Disease?                Yes No

**HEMATOLOGIC**

Do you have or have had problems with Anemia? Yes No Clotting Problems? Yes No  
Have you had a blood clot? Yes No                That went to the lungs? Yes No

Describe the limitations (physical, emotional, social, work related) that morbid obesity imposes on your daily life. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WEIGHT HISTORY**

This is submitted to your insurance company with your letter of medical necessity. Approval or denial of your request for surgery depends on meeting the criteria that your insurance company requires. Please be detailed and complete.

How much did you weigh at birth? \_\_\_\_\_  
What was your weight when you began high school? \_\_\_\_\_

Check if you were of normal, overweight, or morbidly obese at each age group.

	Normal	Overweight/obese	More that 100 lbs overweight
Childhood 1-10 yrs			
Adolescence 11-18			
Young Adult 19-30			
Adult Over 30			

What was your weight in 2002 \_\_\_\_\_ 2003 \_\_\_\_\_ 2004 \_\_\_\_\_  
2005 \_\_\_\_\_ 2006 \_\_\_\_\_ 2007 \_\_\_\_\_

**DIET HISTORY**

List the diet programs you have tried. Add diets that are not listed.

Year	Program	How many pounds did you lose?	How much weight did you re-gain	How long did you stay on the diet?	How many times did you try the diet?
	Optifast				
	Medifast				
	Previous weight loss surgery				
	Weight Watchers				
	TOPS				
	Overeaters Anonymous				
	Diet Center: Jenny Craig, Nutrasystems				
	Prescribed Medications				
	Over the Counter Medications				
	Hypnosis				
	Richard Simmons				
	Slimfast				
	Acupuncture				
	Atkins				
	Other				
	Doctor Supervised diet				

What do you see as your dietary downfall? Where could you improve?

**PHYSICAL ACTIVITY/EXERCISE** (Please circle your answer)

What is your energy level? Fair Poor Good Excellent  
 Are you physically active in your job? Yes No

Please complete the chart on exercise and activity.

PROGRAM	YEAR	How much time do you spend each day on activity	How much weight did you lose?	How much weight did you regain?	How long were you on the program?
Walking					
Bicycle					
Jogging					
Swimming					
Gym Membership					
Aerobics					
Video Tapes					
Home Equipment					
Personal Trainer					
What is your Current exercise activity?					




By signing and dating below, I attest that all information in this document is accurate.

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_