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 _____
Hiatel 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:

_____

_____

_____

_____

_____

_____

Patient signature: _____ Date: _____