Enrollment and Patient Medical History

Please complete all pages and return to the Weight Loss Center before the first appointment.
Fax: 513-475-8880 Email: UCHWeightLoss@UCHealth.com
Mail or drop off: Clifton–222 Piedmont Avenue, Suite 5400, Cincinnati OH 45219
West Chester–7690 Discovery Drive, Suite 1700, West Chester OH 45069

PATIENT INFORMATION

Today's Date: _____ Do you require medical transport? Y/N
Name: Last _____ First: _____ MI: _____
Height: _____ Weight: _____ BMI: _____ Social Security #: _____
Hearing or visually impaired? Y/N Interpreter? Y/N If Yes, language? _____
Former name: _____ Birth date: _____ Age: _____ Sex: M F
Street Address: _____ City: _____ St/zip: _____
Phone: Home _____ Cell _____ Work _____
E-mail Address: _____ UC MyChart? Y/N

Insurance - *Please include a copy of your insurance card, front and back.*

Primary Insurance: _____Subscriber's name: _____
Birth Date: _____ Member ID# _____Subscriber's S.S.#: _____
Phone # for Providers: _____ Occupation: _____
Employer: _____Patient's relationship to subscriber: Self Spouse Parent
Secondary insurance (if applicable): _____
Subscriber's name: _____Birth Date: _____ Member ID#: _____
Phone # for Providers: _____ Subscriber's S.S.#: _____

How did you hear about us?

	Referral	Physician name?					Internet/Search Engine (Google)		
	Insurance		Family/Friend		Social Media		Radio		Brochure/Flyer
	Social Media		Mail		e-mail		Other?		

Which program or clinical service are you interested in?

☐ **Metabolic and Bariatric Surgery** (*Please check procedure you are considering if known.)*

☐ Sleeve Gastrectomy ☐ BPD/DS- Biliopancreatic diversion with duodenal switch

☐ Roux-en-Y Gastric Bypass ☐ SADI-S/Loop DS single anastomosis, duodeno-lleal bypass with sleeve gastrectomy

☐ Revision to prior bariatric/weight loss surgery.

Why do you need a revision? ☐ Complication like GERD or reflux ☐ Lose weight.

☐ **Medical Weight Management.** Nonsurgical weight loss and obesity management options.

PROVIDER INFORMATION

Primary Care Provider			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Other Specialist (Cardiologist, Nephrologist, Kidney Specialist, Endocrinologist, Psychiatrist/therapist, other)			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

Other Specialist (Cardiologist, Nephrologist, Kidney Specialist, Endocrinologist, Psychiatrist/therapist, other)			
First Name:	Last Name:		MD DO PA NP
Street Address:			
City:	State:	Zip:	Phone:

SURGICAL HISTORY

Previous Weight Loss Surgery (Include year of surgery)			
Gastric bypass (RNY or other)		Gastric band	
Stomach stapling		Sleeve Gastrectomy	
Vertical Banded Gastroplasty		BPD/DS	
SADI-S/Loop DS		Other	
Other Past Surgical History (Include year of surgery)			
Past Hospitalizations (Include year)			

ALLERGIES

*List any known food or medication allergies or sensitivities – **please indicate NONE if no medications taken.***

Allergy	Reaction

☐ Latex	Reaction	☐ Dye	Reaction	☐ Iodine	Reaction	☐ Tape	Reaction

PAST/PRESENT MEDICAL HISTORY

(Please circle the appropriate response)

Diabetes	yes	no	past	present	Emphysema/COPD	yes	no	past	present
Age at onset of diabetes:_____					Pneumonia	yes	no	past	present
If yes to diabetes, how controlled?	good	poor			Arthritis	yes	no	past	present
Type I Diabetes	yes	no	past	present	If yes to arthritis, is it located in weight-bearing joint?	_____			
Type II Diabetes	yes	no	past	present	Osteoarthritis	yes	no	past	present
Diabetes while pregnant	yes	no	past	present	Problems with anesthesia	yes	no	past	present
Hypertension (high blood pressure)	yes	no	past	present	Thrombophlebitis	yes	no	past	present
High cholesterol or triglycerides	yes	no	past	present	Abnormal Bleeding	yes	no	past	present
Heart attack	yes	no	past	present	Rheumatic fever	yes	no	past	present
Have pacemaker or defibrillator	yes	no	past	present	Thyroid problems	yes	no	past	present
Congestive heart failure	yes	no	past	Present	Tuberculosis	yes	no	past	present
Coronary heart disease	yes	no	past	present	Urinary tract infections	yes	no	past	present
Heart murmur	yes	no	past	present	Kidney disease	yes	no	past	present
Ever taken Fen-Phen	yes	no	past	present	Bladder/kidney infections	yes	no	past	present
Varicose Veins	yes	no	past	present	Hepatitis/cirrhosis	yes	no	past	present
Blood clots in the legs	yes	no	past	present	Asthma	yes	no	past	present
Blood clots lungs Pulmonary embolism	yes	no	past	present	Take antibiotics for dental work	yes	no	past	present
PCOS (Polycystic ovarian syndrome)	yes	no	past	present	Colitis/enteritis/Crohn's Disease	yes	no	past	present
Stroke	yes	no	past	present	Seizures	yes	no	past	present

Diagnosed Obstructive Sleep Apnea?	yes	no	If yes, do you use a CPAP or BIPAP machine?	yes no
Aspiration/choking at night?	yes	no	Frequent waking at night?	yes no
Tired, fatigued, or sleepy during day?	yes	no	Do you snore loudly?	yes no
Reported stop breathing at night?	yes	no	Neck circumference more than 17in?	yes no

Have you had transplant surgery? YES Date: _____ NO
Are you currently waiting for transplant surgery? YES NO

PSYCHIATRIC

Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential. *Please check all that apply.*

- ☐ Alcoholism/Substance abuse
- ☐ Anorexia
- ☐ Anxiety
- ☐ Attempted suicide
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Binge eating disorder
- ☐ Bipolar disorder (manic-depression) type 1 or type 2
- ☐ Bulimia
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia/Schizoaffective Disorder
- ☐ Sexual abuse (if yes, when? _____)
- ☐ Mental/Emotional abuse (if yes, when? _____)
- ☐ Physical abuse (if yes, when? _____)
- ☐ Self injury or cutting behavior (if yes, when? _____)
- ☐ Other psychiatric illness or condition? Please describe _____
- ☐ Depression

Have you ever had outpatient psychiatric counseling? Yes ☐ No ☐

If yes, for what condition? _____

Have you ever been hospitalized for psychiatric problems? Yes ☐ No ☐ If yes, when? _____

Are you currently seeing a counselor/psychiatric professional? Yes ☐ No ☐

If yes, for what condition(s)? _____

Have you ever been in an alcohol or substance abuse program? Yes ☐ No ☐

If yes, from: _____ to: _____

Are you currently taking medications for anxiety (nerves), depression or other mental health problems?

Yes ☐ No ☐ If yes, who is your prescriber? Name: _____

Address/Phone: _____

SOCIAL HISTORY

Do you currently smoke? yes no

If yes: Age started _____ Age last smoked _____ Avg. # cigarettes/day _____

Do you drink alcohol? yes no

If yes: Number of drinks per week? _____ *(drink= 1 shot, 1 glass of wine, 1 beer or 1 cocktail.)*

Do you use marijuana? yes no **If yes**, how often? _____ ☐ Medical marijuana

Do you use recreational drugs? yes no **If yes**, what? _____ how often? _____

Do you abuse prescription drugs? yes no **If yes**, what? _____ how often? _____

NUTRITION, EATING BEHAVIOR, AND LIFESTYLE HISTORY

Do you track and/or monitor your calories or food intake? yes no

How often do you track calories or food intake?

☐ Daily ☐ 2–3 times a wk ☐ 1 time or less per wk

Are you able to make your own food choices and control your food environment? yes no

Do you experience any barriers to access food? yes no

A. Do you often feel that you can't control what or how much you eat? yes no

B. Do you often eat, within any 2-hour period, what most people regard as an unusually large amount of food? yes no

If yes to <u>both</u> A & B above, has this been as often, on average, as twice a week for the last 3 months? yes no

If yes to <u>both</u> A & B above, In the last 3 months have you often done any of the following to avoid gaining weight? (Check all that apply)

☐ Made yourself vomit?

☐ Took more than twice the recommended dose of laxatives?

☐ Fasted–not eaten anything at all for at least 24 hours?

☐ Exercised for more than an hour specifically to avoid gaining weight After binge eating?

If checked any ways of avoiding gaining weight, were any as often on average as twice a week? yes no

Do you consider your eating patterns chaotic, not eating regular meals? yes no

Do you experience sleepwalking & eating (waking up to see evidence of food consumed without memory of eating)? yes no

Do you consider yourself an emotional/stress eater? yes No

Please note any additional behaviors you would like your care team to be aware of:

On a scale of 1-10 how motivated, are you to change your lifestyle? _____ (*10=highly motivated)*

PHYSICAL ACTIVITY

Do you track and/or monitor your activity? yes ☐ no ☐
If yes, how? (Fitbit, pedometer) _____
Do you exercise on a regular basis? yes ☐ no ☐

Are you able to perform exercises such as walking 3 blocks, swimming, or using exercise bike? yes ☐ no ☐

Average time spent exercising:	**I don't do this**	**1x/week**	**2-3x week**	**4-5x week**	**6+x week**	**Minutes/day**
Walking						
Stretching Exercise (yoga, bands, etc.)						
Weightlifting						
Aerobic						
Other:						

WEIGHT HISTORY

Age you first became overweight _____
Highest adult weight (Age 25 and older) _____lbs.
Weight comfortably maintained _____ lbs.
Lowest adult weight (Age 25 and older) _____ lbs.

Please check all that apply:

Grew up:
☐overweight
☐normal
☐active in
☐under
☐average

Weight gain after:
☐moved
☐marriage
☐divorce
☐separation
☐quit smoking
☐aging
☐desk job
☐injury
☐gradual
☐surgery

MEDICATIONS

List all daily medications including over the counter (aspirin, ibuprofen, Aleve, allergy medications, etc.), vitamins, herbs or supplements, and contraceptives. ***Please indicate NONE if no medications taken****.*

Name	Dosage	Frequency	Reason

Specific weight loss medications – check all that apply.

Medication	✓	Medication	✓	Medication	✓	Medication	✓
Acutrim		Dexatrim		Mazanor		Plegine	
Adepex-P		Didrex		Meridia		Pondimin	
Alli		Fastin		Metabolife		Redux	
Amphetami		Fenfluramine		Mounjaro		Sanorex	
Anorex		Qsymia		Orlistat		Saxenda	
Belviq		Herbal Remedies		Ozempic		Tenuate	
Benzphetam		Ionamin		Phentermine		Wehless	
Contrave		Liraglutide		Phenfen		Wegovy	
Other		Other		Other		Xenical	

Do you take any of the following over-the-counter medications regularly?

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	no

FAMILY MEDICAL HISTORY

Please indicate if you have a family history of the following:

Are you adopted? Yes No

Parent(s): **Mother** ☐ alive ☐ deceased **Father** ☐ alive ☐ deceased

Sibling(s): **Brother(s):** How many alive? _____ How many deceased? _____

Sister(s): How many alive? _____ How many deceased? _____

Children: How many alive? _____ How many deceased? _____

Please complete the below section if NOT adopted.

	Parent(s)		**Sibling(s)**		**Other Relatives** *cousins, aunts, grandparents, etc.*	**No Family History**	**Don't Know**
	Mother	*Father*	*Brother*	*Sister*			
Diabetes							
Blood clots legs							
Blood clots lungs – pulmonary							
Heart Disease							
Hypertension							
Gallstones							
Obesity							
Sleep Apnea							
Asthma							
Cancer *(specify type)*							
Depression							
High Cholesterol							
Osteoporosis							
Stroke							
Chemical dependency							
Alcohol Abuse							
Bipolar disorder							
Anesthesia problems							
Schizophrenia							