University of Colorado Hospital
Surgical Weight Loss Center
ANSCHUTZ MEDICAL CAMPUS

Surgical Weight Loss Center
Patient Intake Form

Dear Patient,

Please completely fill out the following history form to the best of your abilities. It provides us with important information regarding your health and candidacy for weight loss surgery. If you have a lengthy surgical history or you are on multiple medications, you may write these items on a separate page.

Please be sure to bring this with you to your first appointment. Without it we will need to reschedule your visit. Thank you.

Name:_____
Address:_____
Phone: Day:_____ Evening:_____
Email:_____
Who may we thank for referring you? _____

Obesity Related Co-morbidities

Severity of Symptoms: Please circle the answer that applies to you

Mild (symptoms are bothersome/hardly affect my daily living)
Moderate (symptoms are difficult to tolerate/affect my daily living)
Severe (symptoms affect my daily living)

Onset of weight gain:

Childhood
Adolescence
Adulthood
After Childbearing

Are you at your maximum weight now? Yes No

Do you have diabetes?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Do you take insulin? Do you check your sugars at home? What are they?

Have you suffered from any diabetic complications? (ex. Nerve damage, vision changes, foot ulcerations.)

Do you have COPD?
Yes (year of diagnosis:_____) No

Do you use oxygen?
Yes (setting:_____) No Not currently, but have in the past

Do you use this during the day or night?

Do you have asthma?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Have you ever been hospitalized for asthma treatment?

Do you have obesity hypoventilation syndrome?
Yes (year of diagnosis:_____) No Not currently, but have in the past

If yes, who is your treating physician and what is your treatment plan?

Do you have sleep apnea?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Have you had a sleep study? Where and when were you tested?

Do you use CPAP or BiPAP?
Yes (setting:_____) No

Have you ever had a deep vein thrombosis (DVT) or a pulmonary embolism (PE)?
Yes No

If so, when did this occur?

How was this treated?

Do you have hypertension (high blood pressure)?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Have you suffered any complications from hypertension? (ex. Stroke, kidney problems.)

Have you had a heart attack?
Yes No

Have you ever had heart surgery or a stent placement?
Yes No

Do you have high cholesterol or triglycerides?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Do you have heartburn or gastro esophageal reflux disease (GERD)?
Yes (year of diagnosis:_____) No Not currently, but have in the past

How often do you take medication for this?

Have you ever had tests for this? (ex. Endoscopy in which a camera is placed in the stomach.) If so, when and where was this done? What were the results?

Have you suffered from any complications related to GERD? (ex. Barrett's esophagitis, anemia.)

Have you ever been treated for ulcers?
Yes No

Have you ever been treated for h. pylori?
Yes No

Have you ever had gallbladder disease?
Yes No

Do you have urinary stress incontinence (leakage of urine when laughing, sneezing or coughing)?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Do you wear pads? How often?

Do you have a connective tissue disorder or autoimmune disease? (ex. Lupus or Ehlers-Danlos Syndrome.)
Yes No

Do you use steroids for a chronic condition?
Yes No

Do you have chronic joint pain or arthritis?
Yes (year of diagnosis:_____) No Not currently, but have in the past

Where is it located?

Is your mobility limited all or most of the time?
Yes No

Is your activity limited by pain?
Yes No

Do you take daily medication for this?
Yes No

Have you had surgery for this or is surgery planned in the future?
Yes No

Have you ever had an eating disorder?
Yes No

What type? (ex. Anorexia, bulimia, binge eating.)

Have you undergone treatment?

Do you suffer from depression or another mental health problem such as bipolar or anxiety disorder?
Yes No

What type?

Are you involved in therapy or a support group?

Do you take medications for this?

Have you ever considered harming yourself or others?

Do you have gout?
Yes No

Do you have PCOS (polycystic ovarian syndrome)?
Yes No

Past Medical History
Primary Care Provider?_____
Telephone:_____Fax:_____
Address:_____
_____

Date of last PAP smear/pelvic exam:_____ Was it normal?

Date of last mammogram:_____ Was it normal?

Any abnormalities in the past? Yes No

Treatment:

Date of last colonoscopy:_____ Was it normal?

Any abnormalities in the past? Yes No

Treatment:

Date of last stress test:_____ Was it normal?

Date of last EKG:_____ Was it normal?

Date of last echocardiogram (ultrasound of the heart):_____

Was it normal?

Have you ever had any of the following? If yes, please describe.

Rectal disease Yes No

Jaundice Yes No

Hepatitis Yes No

HIV Yes No

Frequent infections Yes No

Cancer Yes No

Anemia Yes No

Heart Problems Yes No

Colitis, Bowel Disease, Crohns, Ulcerative colitis Yes No

Thyroid disorder Yes No

Respiratory Problems Yes No

Infertility Yes No

Severe Headaches Yes No

Miscarriage (how many?_____)

Blood Transfusion Yes No

Surgical History

Please list any surgeries you have had, including the year.

1.

2.

3.

4.

5.

6.

Family History (please list only if applicable to your parents, siblings, or grandparents)

Do you have a relative with cancer? Yes No Who:
What type?

Do you have a relative with heart disease? Yes No Who:

Do you have a relative with a blood clotting disorder? Yes No Who:

Do you have a relative who has had a stroke? Yes No Who:

Do you have a relative with diabetes? Yes No Who:

Do you have a relative with obesity? Yes No Who:

Social History

Marital status: Single Married Widowed Divorced

Is your spouse supportive of your desire for weight loss surgery?
Yes No If no, please explain

Education: High School GED College Post-graduate

Occupation:_____

Do you smoke? Yes No Not currently, but have in the past
For how many years?_____ How many packs per day?_____
Time since quitting?_____

Do you drink alcohol? Yes No Not currently, but have in the past

Do you use recreational drugs? Yes No Not currently, but have in the past
What type?_____

Have you ever had a problem with substance abuse? Yes No

Do you consider yourself to be a sweets eater? Yes No

Gynecological History

Do you use hormone replacement therapy? Yes No Not currently

How many children do you have?

How many vaginal deliveries?_____ How many C-sections?_____

Do you use any contraception (birth control)? Yes No Not currently

Have you undergone infertility treatment? Yes No If yes, please describe treatment_____

Medications

	Drug Name	**Dose**	**Frequency**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list any non-prescription medications or herbal supplements:

_____
_____
_____

Are you allergic to any medications? Please list medication and reaction:

_____
_____

Weight Loss History

How many weight loss attempts have you made in your life?

1-3 3-10 10-25 >25

Among the following exercise programs, please provide information for those you have tried:

	Months on Program	Weight Loss	Weight Gain
Health Club	_____	_____	_____
Walking	_____	_____	_____
Jogging	_____	_____	_____
Bicycling	_____	_____	_____
Swimming	_____	_____	_____
Aerobics	_____	_____	_____
Personal Trainer	_____	_____	_____
Physical Therapy	_____	_____	_____
Other	_____	_____	_____

Among the following weight loss programs, please provide information for those you have tried:

	Months on Program	Weight Loss	Weight Gain
Fen-Phen/Redux	_____	_____	_____

	Months on Program	Weight Loss	Weight Gain
Xenical	_____	_____	_____
Meridia	_____	_____	_____
Medifast	_____	_____	_____
Nutrisystem	_____	_____	_____
Weight Watchers	_____	_____	_____
Jenny Craig	_____	_____	_____
Metabolife	_____	_____	_____
Herbalife	_____	_____	_____
Richard Simmons	_____	_____	_____
Atkins	_____	_____	_____
Sugar Busters	_____	_____	_____
Slim Fast	_____	_____	_____
Slim for Life	_____	_____	_____
Overeaters Anon.	_____	_____	_____
Hypnosis	_____	_____	_____
Acupuncture	_____	_____	_____
Nutritionist	_____	_____	_____
Psychotherapy	_____	_____	_____
Behavior Mod	_____	_____	_____
Wired Jaw	_____	_____	_____
Surgery	_____	_____	_____
South Beach Diet	_____	_____	_____
The Zone	_____	_____	_____
Alli	_____	_____	_____
Metabolic Research Center	_____	_____	_____
Colorado Weigh	_____	_____	_____
LA Weight Loss	_____	_____	_____
HCG Diet	_____	_____	_____
Blood Type	_____	_____	_____
Body for Life	_____	_____	_____
Other	_____	_____	_____

Have you ever had a physician monitored weight loss plan? Yes No

OFFICE USE ONLY BELOW

BP	TEMP	HR	RR	O2 SAT

WEIGHT	HEIGHT	BMI	IDEAL WT.

Obesity Related Co-morbidities **Other PMH**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.