Please bring this form to your first appointment at the USA Center for Surgical Weight Loss

University of South Alabama
Center for Weight Loss Surgery™

For Office Use Only: USASWL DEMOGRAPHIC FORM
MRN _____
Dr. _____
Date _____

Patient Demographic Information (Please fill out as completely as possible)

Name			Date of Birth	Sex	Marital Status
Street Address			Home Phone		Cell or Work Phone
City	State	Zip Code	E-mail Address		
Employer's Name	Occupation		Emergency Contact		Relationship
Employer's Street Address			Street Address		
City	State	Zip Code	Home Phone		Cell or Work Phone
What type of surgery do you prefer? Please check: ☐ Gastric Bypass ☐ Gastric Band ☐ Sleeve Gastrectomy ☐ Undecided			Social Security Number		
			Race (optional) ☐ African-American ☐ Caucasian ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander Other _____		

Primary Insurance			Secondary Insurance		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Customer Service Phone Number			Customer Service Phone Number		
Policy or ID Number			Policy or ID Number		
Group and/or Contract Number			Group and/or Contract Number		
Subscriber's Name			Subscriber's Name		
Relationship to Patient			Relationship to Patient		
Subscriber's Employment			Subscriber's Employment		

Have you had any other surgical procedure for weight loss? ☐ Yes ☐ No

I authorize the release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

Signature: _____

Weight and Diet History:

Name _____ Date attended seminar _____/_____/ _____

Date of first USA Weight Loss Surgery Center consultation _____/_____/ _____

Body weight _____ Height _____

Weight history:

Birth weight _____ Start of high school_____

High school graduation _____ Marriage _____

Lowest weight in past five (5) years _____ Highest weight in past five (5) years _____

For female patients:

Age at first period _____ Date of last period _____

Are you menstruating regularly? ☐ Yes ☐ No

Pregnancy History

Number of pregnancies_____ Number of live births _____

Year of pregnancy _____ Weight at start _____ at delivery_____

Miscarriages/abortions (#)_____ Obstetric complications _____

Dietary history:

Approximate age when you first seriously dieted _____

Check the programs that you have tried:

Self-Directed	Diet plans	Group	Medications
☐ Reducing portions	☐ Atkins	☐ Weight Watchers®	☐ Phen-fen
☐ Decrease snacks	☐ Carbohydrates Addict	☐ Nutrisystem®	☐ Redux
☐ Decrease sweets	☐ Cabbage soup	☐ Overeaters Anon	☐ Alli
☐ Exercises	☐ Sugar Busters	☐ Jenny Craig®	☐ Lindora
	☐ Pritikin Diet	☐ Other	☐ Meridia
	☐ Slimfast		☐ Metabolife
	☐ Other		☐ Xenical
			☐ Other _____

Did you ever have physician supervised diet? ☐ Yes ☐ No When?_____/_____/_____

Previous weigh loss surgery:

☐ Stapling ☐ Gastric Banding ☐ Gastric Bypass ☐ Biliary-pancreatic Diversion
☐ Sleeve Gastrectomy ☐ Other

Dietary habits: *Please list everything you have eaten in the last 24 hours*

Breakfast

_____

_____

Lunch

_____

_____

Dinner

_____

_____

Snacks

_____

_____

Beverages

_____

_____

Eating habits: *Have you / do you?*

☐ binge eating ☐ eaten more food than others in a two (2) hour period
☐ unable to stop eating or control how much ☐ eat rapidly ☐ eat until stuffed
☐ eat alone due to embarrassment ☐ snack eating (candy)
Frequently this occurs during a week _____

Food preferences: (*list on scale of 10 with 10 being most preferred*)

_____ Cake/pie
_____ Candy
_____ Chips/snacks
_____ Chocolate
_____ Cookies
_____ Fast food
_____ French fries
_____ Fried food
_____ Nuts
_____ Pasta
_____ Pizza
_____ Potatoes
_____ Salad dressing and type _____
_____ Soft drinks
Other _____

Do you buy groceries? ☐ Yes ☐ No

Do you read labels? ☐ Yes ☐ No

Do you eat in restaurants? ☐ Yes ☐ No

How many times per week? _____

List your favorite restaurants: _____

_____

_____

Do you find yourself doing emotional eating in response to stress / anxiety? ☐ Yes ☐ No

Do you have specific food cravings? ☐ Yes ☐ No If yes, please list them:

_____

_____

Behavior and Exercise (please fill in or check answers):

Are you able to exercise? ☐ Yes ☐ No

If yes:

How many times a week? _____

What type of exercise do you do? _____

Where do you exercise:_____

If no:

What is the most physically active thing you do? _____

What limits your activity: (Please check)

☐ Pain in my knees

☐ Getting tired or short of breath

☐ I don't know what activities are safe for me

☐ Pain in my chest

☐ A doctor told me not to due to my illness

Injury _____

Other _____

Medical Problems:

(*Please check all the medical problems that you have had in your life*)

☐ Heart attack ☐ Thrombophlebitis (clots in legs) ☐ High blood pressure ☐ Thyroid problems

☐ Gastroesophageal reflux disease (heartburn) ☐ Stomach ulcers ☐ Depression

☐ Anxiety ☐ Diabetes ☐ Arthitis/Joint pain ☐ Polycystic ovaries ☐ High cholesterol

☐ Fibromyalgia ☐ Cancer (type:_____) ☐ Asthma

☐ Sleep apnea (CPAP or BiPap Pressure:_____) ☐ Kidney disease

Other:_____

Weight history:

Most weight lost on a diet _____

Name of that diet_____

How long did you maintain that weight? _____

Please list **weight loss medications** (include over the counter/herbal) that you have tried for the past five (5) years.

Medication Used	Date Started	Date Ended	Weight When Started	Weight When Ended	Why Did You Stop?

Previous surgeries/procedures:

(Please check all the surgeries that you have had. Specify the year.)

☐ Gallbladder removed Year _____

☐ Appendectomy Year _____

☐ Hysterectomy Year _____

☐ Colon surgery Year _____

☐ Tubal ligation Year _____

☐ Hernia Year _____

☐ Weight Loss Surgery Year _____

Other _____

Year _____

Current Medications:

(List all medications with proper dosages or bring in list if cannot fit in columns below.)

Prescription Medication:	Over the counter Medication:	Vitamins & Minerals:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

(List anything that you are allergic to including medications or foods.)

_____

_____

_____

Social history:

Do you smoke or have you smoked in the past? ☐ Yes ☐ No

If yes, for how long and how many packs/day? _____

Have you quit smoking? ☐ Yes ☐ No

If no, are you trying to quit?_____ If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No. If yes, how frequently and how many drinks / week? _____

Are you currently experiencing any of the following problems? (Please check Yes or No)

Constitutional:	fevers	☐ Yes ☐ No
	chills	☐ Yes ☐ No
Sleep:	excessive daytime sleepiness	☐ Yes ☐ No
	snoring	☐ Yes ☐ No
	episodes when you quit breathing during your sleep	☐ Yes ☐ No
HEENT:	frequent headaches	☐ Yes ☐ No
	feeling like food gets stuck when you swallow	☐ Yes ☐ No
Cardiovascular:	chest pain	☐ Yes ☐ No
	difficulty breathing when lying flat	☐ Yes ☐ No
	shortness of breath with exertion	☐ Yes ☐ No
	feeling that your heart is beating irregularly	☐ Yes ☐ No
	significant swelling of your legs	☐ Yes ☐ No
Respiratory:	frequent cough	☐ Yes ☐ No
	frequent wheezing	☐ Yes ☐ No
GI:	frequent nausea	☐ Yes ☐ No
	frequent heartburn	☐ Yes ☐ No
	frequent diarrhea	☐ Yes ☐ No
	frequent constipation	☐ Yes ☐ No
	passing blood in your bowel movements	☐ Yes ☐ No
	frequent abdominal pain	☐ Yes ☐ No
GU:	painful urination	☐ Yes ☐ No
	blood in your urine	☐ Yes ☐ No
Musculoskeletal:	joint pains	☐ Yes ☐ No
	back pains	☐ Yes ☐ No
	frequent muscular pain	☐ Yes ☐ No
Neurologic:	dizziness	☐ Yes ☐ No
	seizures	☐ Yes ☐ No
	numbness	☐ Yes ☐ No
	specific areas of muscle weakness	☐ Yes ☐ No
Psychiatric:	depression	☐ Yes ☐ No
	anxiety	☐ Yes ☐ No
Dermatologic:	rashes	☐ Yes ☐ No
	non-healing wounds	☐ Yes ☐ No
Endocine:	frequent urination	☐ Yes ☐ No
	excessive thirstiness	☐ Yes ☐ No
Hematologic:	easy bruising	☐ Yes ☐ No
	frequent nose bleeds	☐ Yes ☐ No

Do you use any of the following devices for assistance? (Please check)

☐ walker ☐ cane ☐ wheelchair ☐ other _____ ☐ none

Do you use assistance with any of the following activities? (Please check)

☐ eating ☐ bathing ☐ walking ☐ other _____ ☐ none

Please describe in your own words your reason for wanting to lose weight, what you want to accomplish and what life change do you anticipate. Feel free to use the back of this page.