

**Tomorrow's Weigh  
Confidential Information**

**Patient Information:**

|                                  |       |              |   |     |                          |                           |
|----------------------------------|-------|--------------|---|-----|--------------------------|---------------------------|
| Last name, first, middle initial |       |              | Date of Birth                                   | Sex | Age                      | Marital Status<br>M D S W |
| Street Address                   |       |              | Home Phone                                      |     | Cell Phone and/or Pager: |                           |
| City                             | State | Zip Code     | Work Phone                                      |     | Occupation:              |                           |
| Employer's Name                  |       |              | Driver's License Number / State in Which Issued |     |                          |                           |
| Employer's Street Address        |       |              | Social Security Number                          |     |                          |                           |
| City                             | State | Zip Code     | E-Mail Address:                                 |     |                          |                           |
| Emergency Contact:               |       | Relationship | Home Phone                                      |     | Work Phone               |                           |
| Address:                         |       |              | Religious Preference                            |     | Surgeon Choice:          |                           |

**Insurance Information:**

|                               |                               |
|-------------------------------|-------------------------------|
| Primary Insurance             | Secondary Insurance           |
| Address                       | Address                       |
| Customer Service Phone Number | Customer Service Phone Number |
| Policy or ID Number           | Policy or ID Number           |
| Group Number                  | Group Number                  |
| Subscribers Name              | Subscribers Name              |
| Relationship to Patient       | Relationship to Patient       |
| Subscriber's Employer         | Subscriber's Employer         |

**\* Will need a copy of front and back of insurance card(s) and driver's license (or photo ID).**

Surgery Preference?:  Gastric Bypass (Open)  Gastric Bypass (Laparoscopic)  Adjustable Lap-Band

How did you hear about us?  Physician Referral  Newspaper Article  Internet  
 Lecture Date: \_\_\_\_\_  Friend Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Nacogdoches Medical Center - Tomorrow's Weigh

## Patient History Questionnaire

**The information requested in this questionnaire is very important. To give you the best care, we must have complete answers. Please be thorough. Please print clearly and use blue or black ink only.**

|                         |                |     |   |        |       |
|-------------------------|----------------|-----|---|--------|-------|
| Actual Body Weight      |                |     | Date of Last Weight                                       |        |       |
| Height                  | Waist (Inches) | BMI | Location where weighed (physician office, hospital, etc.) |        |       |
| Target (or Goal) Weight |                |     | Body Frame Size   |        |       |
|                         |                |     | Small   | Medium | Large |

### Weight History

*Please estimate as closely as possible for all that applies.*

| Life Event                     | Age | Weight |
|--------------------------------|-----|--------|
| Birth Weight                   |     |        |
| Start of High School           |     |        |
| High School Graduation         |     |        |
| Marriage                       |     |        |
| Lowest Weight in Past 5 Years  |     |        |
| Highest Weight in Past 5 Years |     |        |

*In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:*

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### Dietary History

Approximate age when you first seriously dieted: \_\_\_\_\_

List the diets and diet programs you have tried:

| Program                   |                              |                             | Dates | Duration | Professionally Supervised? | Max Loss |
|---------------------------|------------------------------|-----------------------------|-------|----------|----------------------------|----------|
| Fen/Phen/Reduc            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Meridia                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Xenical                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Metabolife                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Atkins Diet               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Acupuncture               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Jenny Craig               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Nutri-System              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Weight Watchers           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| OptiFast/Medi-Fast        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Richard Simmons           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| T.O.P.S.                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Calorie Counting          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |
| Other Prescription/ Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____    |                            |          |

List: \_\_\_\_\_

List any other physician-supervised and documented weight loss attempt:

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List any other diets and/or weight loss methods you've tried:

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# Nacogdoches Medical Center - Tomorrow's Weigh

## Food Preferences

Indicate which foods you prefer (which foods would most likely make you go off a diet):

Rank each selection from **1 – Like very much, 2 – Enjoy sometimes, 3 – Rarely eat, or 4 – Don't care for**

|                      |                  |                         |                       |
|----------------------|------------------|-------------------------|-----------------------|
| ___ Soda/Soft Drinks | ___ French Fries | ___ Chips/Snacks        | ___ Steaks/Pork Chops |
| ___ Candy            | ___ Potatoes     | ___ Chocolate           | ___ Pasta             |
| ___ Cookies          | ___ Pizza        | ___ Cakes/pies/desserts | ___ Salad Dressings   |
| ___ Fried Foods      | ___ Nuts         | ___ Sweet Beverages     | ___ Alcohol           |

## Weight Related Illnesses

Have you had, or do you have, any of the following illnesses or symptoms:

1. Heart Disease  Yes  No

If Yes: Year Diagnosed \_\_\_\_\_

Do you have, or have you had:

- Angina
- M.I. (Myocardial Infarction/heart attack)
- CABG (coronary artery bypass graft/open heart surgery)
- Abnormal EKG
- Stress test to rule out cardiac problems
- Palpitations
- Pacemaker

List Heart

Medications/Treatment: \_\_\_\_\_

2. High Cholesterol  Yes  No High Triglycerides  Yes  No

If Yes: Year Diagnosed \_\_\_\_\_

List Medications/Treatment: \_\_\_\_\_

3. High Blood Pressure  Yes  No

If Yes: Year Diagnosed \_\_\_\_\_ Last Blood Pressure: \_\_\_\_/\_\_\_\_ Date: \_\_\_\_\_

List Medications/Treatments \_\_\_\_\_

4. Diabetes  Yes  No

If Yes: Year Diagnosed \_\_\_\_\_

Controlled with:

- Diet
- Oral Medication (list) \_\_\_\_\_
- Insulin (list type/dose) \_\_\_\_\_

◆ Last Fasting Blood Sugar Reading: \_\_\_\_\_

5. Asthma  Yes  No

If Yes: Year Diagnosed \_\_\_\_\_

ER Visits for Asthma in last 2 years: \_\_\_\_\_

Hospitalizations for Asthma in last 2 years: \_\_\_\_\_

Steroids in last 2 years:  Yes  No Home Breathing Machine  Yes  No

Use an inhaler  Yes  No If Yes; which Inhaler: \_\_\_\_\_

List Asthma Medications: \_\_\_\_\_

## Nacogdoches Medical Center - Tomorrow's Weigh

Patient Name: \_\_\_\_\_

6. Shortness of Breath  Yes  No

If Yes:

Can Walk \_\_\_\_\_ Blocks without getting short of breath

Climb Stairs \_\_\_\_\_ Flights of stairs can walk without getting short of breath

7. Trouble Sleeping?  Yes  No

◆ Morning Headaches  Yes  No

◆ Daytime drowsiness  Yes  No

◆ Restless sleep  Yes  No

◆ Snoring  Yes  No

◆ Frequent Awakenings at night  Yes  No

◆ Observed not breathing in sleep  Yes  No

8. Sleep Apnea Syndrome  Yes  No

If Yes; Year Diagnosed: \_\_\_\_\_

Last Sleep Study: \_\_\_\_\_ (month/year)

CPAP Used  Yes  No BiPAP  Yes  No Oral Appliance  Yes  No

9. Heartburn/GERD - Reflux/Hiatal Hernia?  Yes  No

If Yes; Year Diagnosed: \_\_\_\_\_

What tests/procedures were performed? \_\_\_\_\_

Medications: \_\_\_\_\_

How often do you have take your medications? \_\_\_\_\_

10. Belching up acid or sour fluid?  Yes  No

11. Cough or choking at night?  Yes  No

12. Do you still have your gallbladder?  Yes  No

If yes; do you have gallbladder disease?

Yes  No

If Yes; How was it diagnosed?

Ultrasound  Physical Exam

13. Leakage of urine with laughing/coughing/sneezing?  Yes  No

If yes; do you wear pads frequently?  Yes  No

14. Back strain/Pain/Sciatica?  Yes  No If yes, where is pain? \_\_\_\_\_

If yes; have you been seen by a Chiropractor?  Yes  No

have you been seen by a Orthopedic Surgeon?  Yes  No

have you been seen by your family doctor?  Yes  No

What treatments have you been on for this problem?

\_\_\_\_\_  
What medications do you take for this problem?

15. Pain in Hips/Knees/Ankles/Feet?  Yes  No If yes, where is pain? \_\_\_\_\_

If yes; have you been seen by a Chiropractor?  Yes  No

have you been seen by a Orthopedic Surgeon?  Yes  No

have you been seen by your family doctor?  Yes  No

What treatments have you been on for this problem?

\_\_\_\_\_  
What medications do you take for this problem?

\_\_\_\_\_



# Nacogdoches Medical Center - Tomorrow's Weigh

Patient Name: \_\_\_\_\_

**Please list below what surgeries you have had performed:**

| <u>Surgery</u> | <u>Date</u> | <u>Doctor</u> | <u>Hospital</u> |
|----------------|-------------|---------------|-----------------|
|                |             |               |                 |
|                |             |               |                 |
|                |             |               |                 |
|                |             |               |                 |
|                |             |               |                 |

Did you experience any problems with your anesthesia?       Yes    No  
If yes; What type? \_\_\_\_\_

**Allergies:**  
Allergic to any medications?       Yes    No      If Yes; please list medication and reaction:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergic to: **Surgical Tape?**  Yes    No   **Latex?**  Yes    No   **Iodine?**  Yes    No  
Other Allergies:  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:**    *(Include all Over-The-Counter Medications, Herbal/Vitamin Supplements you take)*  
*Please list below all medications you currently use:*

| <b>Medication</b> | <b>Dose and Frequency</b> |
|-------------------|---------------------------|
|                   |                           |
|                   |                           |
|                   |                           |
|                   |                           |
|                   |                           |
|                   |                           |
|                   |                           |
|                   |                           |

Do you use tobacco?       Yes    No    If Yes; What type and Frequency: \_\_\_\_\_  
If Yes; are you willing to quit?       Yes    No  
If No; have you ever used tobacco?  Yes    No  
If Yes; What type and frequency: \_\_\_\_\_  
How long have you quit? \_\_\_\_\_

Do you use alcohol?       Yes    No    If Yes; Frequency: \_\_\_\_\_

Do you use illegal drugs?       Yes    No

Patient Name: \_\_\_\_\_

## Nacogdoches Medical Center - Tomorrow's Weigh

### Family History

| Family Member            | Living<br>Yes or No | Age | If deceased<br>Age at Death | Illnesses<br>and/or Cause of death | Obese or<br>Weight Problem |
|--------------------------|---------------------|-----|-----------------------------|------------------------------------|----------------------------|
| Mother                   |                     |     |                             |                                    |                            |
| Father                   |                     |     |                             |                                    |                            |
| Maternal<br>Grandmother  |                     |     |                             |                                    |                            |
| Maternal<br>Grandfather  |                     |     |                             |                                    |                            |
| Fraternal<br>Grandmother |                     |     |                             |                                    |                            |
| Fraternal<br>Grandfather |                     |     |                             |                                    |                            |
| Sibling:                 |                     |     |                             |                                    |                            |
| Sibling:                 |                     |     |                             |                                    |                            |
| Sibling:                 |                     |     |                             |                                    |                            |
| Sibling:                 |                     |     |                             |                                    |                            |

*Please indicate if there is a family history of:*

- |   |  |
|---|--|
| <input type="checkbox"/> Obesity<br><input type="checkbox"/> Lung Disease, Asthma, or Emphysema<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding tendency or Blood Disorder<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Breast Cancer<br><input type="checkbox"/> High Blood Cholesterol<br><input type="checkbox"/> Colon Cancer |
|---|--|

### Personal Physicians:

*Please list all the physicians under whom you receive medical care:*

| Specialty                 | Name | Address | Telephone |
|---------------------------|------|---------|-----------|
| Primary Care Physician    |      |         |           |
| Internist                 |      |         |           |
| Cardiologist              |      |         |           |
| Pulmonologist             |      |         |           |
| Gynecologist              |      |         |           |
| Orthopedist               |      |         |           |
| Psychologist/Psychiatrist |      |         |           |
| Therapist                 |      |         |           |
| Other                     |      |         |           |
| Other                     |      |         |           |

Patient Name: \_\_\_\_\_

**Nacogdoches Medical Center - Tomorrow's Weigh  
Medical System Review**

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or important information. List any treatments you are on for these symptoms.

1. **HEAD, EYE, EAR, NOSE, & THROAT:** Stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness  
Comments and/or Treatments: \_\_\_\_\_
  
2. **RESPIRATORY:** cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis  
Comments and/or Treatments: \_\_\_\_\_
  
3. **CARDIOVASCULAR:** palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attached – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses  
Comments and/or Treatments: \_\_\_\_\_
  
4. **GASTROINTESTINAL:** heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis  
Comments and/or Treatments: \_\_\_\_\_
  
5. **GENITOURINARY:** pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze  
Comments and/or Treatments: \_\_\_\_\_  
\_\_\_\_\_  
◆ Men: Discharge from penis – loss of erection – painful erection  
◆ Women: Vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods  
Comments and/or Treatments: \_\_\_\_\_
  
6. **ENDOCRINE (GLANDULAR):** low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating  
Comments and/or Treatments: \_\_\_\_\_
  
7. **MUSCULOSKETETAL:** pain in joints – swelling in joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica  
Comments and/or Treatments: \_\_\_\_\_
  
- 8: **NEUROLOGICAL:** dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness  
Comments and/or Treatments: \_\_\_\_\_
  
9. **PSYCHOLOGICAL:** nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling  
Comments and/or Treatments: \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_