



Please read the following important information before submitting your forms:

- 1. All sections of the Patient Medical History Form must be completed to process your application.**
- 2. When completing any section with a yes or no answer, either a yes or no must be marked. A non-answer cannot be interpreted as a no.**
- 3. All current medications taken, and their indications must be included on this form. We will not get this information from your UC Health chart.**

Any incomplete forms will be mailed back to the patient for completion prior to checking insurance benefits and scheduling any appointments.

UC Health Weight Loss Center

7690 Discovery Drive, Suite 1700
West Chester, OH 45069

Phone: 513-939-2263 Fax: 513-475-8880
www.UCHealth.com/weightloss

Patient Medical History Form

Today's Date: _____

PATIENT INFORMATION

Height: _____ **Weight:** _____ **BMI:** _____

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms Dr.

Hearing impaired? Yes No Visually impaired? Yes No Other limitations? _____

Medical transport required? Yes No Need interpreter? Yes No Language: _____

Marital status: Single Married Divorced Separated Widow

Is this your legal name? Y N If no, what is your legal name? _____

(Former name): _____ Birth date: _____ Age: _____ Sex: M F

Street Address: _____ City: _____ St.: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

What number do you prefer to be contacted? Home Cell Work

E-Mail Address: _____

Occupation: _____ Employer: _____

REQUIRED INSURANCE INFORMATION

Please indicate primary insurance: _____

Subscriber's name: _____ Member ID # _____

Phone # for Providers: _____ Subscriber's S.S.#: _____

Occupation: _____ Employer: _____

Patient's relationship to subscriber: Self Spouse

Name of secondary insurance (if applicable): _____

Subscriber's name: _____

Subscriber's name: _____ Member ID # _____

Phone # for Providers: _____ Subscriber's S.S.#: _____

PROGRAM INFORMATION

Date Seminar Attended: _____

How did you hear about us? (Please check one box):

Physician Insurance plan Hospital Family/Friend TV WEB Other _____

I am interested in:

NON SURGICAL MEDICAL WEIGHT LOSS

RETURNING TO NON SURGICAL MEDICAL WEIGHT LOSS

SURGERY (please choose a surgical procedure in which you are interested)

Gastric sleeve surgery

Gastric balloon

Gastric band surgery (LapBand)

Gastric bypass surgery

Revision: (Please explain) _____

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Primary Care Provider			
First Name:	Last Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Street Address:			
City:	State:	Zip:	Phone:
Cardiologist			
First Name:	Last Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Street Address:			
City:	State:	Zip:	Phone:
Pulmonologist			
First Name:	Last Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Street Address:			
City:	State:	Zip:	Phone:
Psychological Services			
First Name:	Last Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Street Address:			
City:	State:	Zip:	Phone:
Other Specialist			
First Name:	Last Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA	
Street Address:			
City:	State:	Zip:	Phone:

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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,	good	poor			Arthritis	yes	no	past	present
Diabetes control			past	present					
Type I Diabetes	yes	no	past	present	If yes to arthritis, where: _____	yes	no	past	present
Type II Diabetes	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	AIDS/HIV	yes	no	past	present
Blood clots to the lungs/Pulmonary embolism	yes	no	past	present	Do you have to take antibiotics before 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
Asthma	yes	no	past	present					

Past Surgical History Please list all surgeries and approximate dates (year)	Past Hospitalizations Please list all hospitalizations and approximate dates (year)	Comorbidities office use only

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Past/Present Medical History (continued)

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.

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

Have you ever had outpatient psychiatric counseling?

Yes No If yes, for what condition(s)?

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: _____

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Review of Systems

General				Physical Activity Limitations			
Fevers	Yes	no		Climbing stairs	yes	no	
Sweats	Yes	no		Unusual fatigue	yes	no	
Fatigue	yes	no		Airline travel	yes	no	
Loss of appetite	yes	no		Lifting from floor	yes	no	
Skin				Tying shoelaces	yes	no	
Rash	yes	no		Playing with children	yes	no	
Acne	yes	no		Pain in joints			
Skin cancer	yes	no		Back	yes	no	
Skin Darkening	yes	no		Hips	yes	no	
Neck	yes	no		Knees	yes	no	
Underarms	yes	no		Feet	yes	no	
Groin	yes	no		Gastrointestinal			
Vision				Heartburn/acid reflux	yes	no	
Visual problems	yes	no		Heartburn/acid reflux (5+ years)	yes	no	
Hearing				EGD/Stomach Scope	yes	no	
Hearing problems	yes	no		If yes, when? _____			
Ear ringing	yes	no		Stomach pains	yes	no	
Neurological				Stomach ulcers	yes	no	
Dizziness	yes	no		Gastritis	yes	no	
Migraines	yes	no		H. pylori infection	yes	no	
Frequent headaches	yes	no		Rectal Bleeding	yes	no	
Memory loss	yes	no		Liver disease	yes	no	
Shaking	yes	no		Frequent diarrhea	yes	no	
Numbness	yes	no		Frequent constipation	yes	no	
Incoordination	yes	no		Stomach surgery	yes	no	
Genito-urinary				Sleep Apnea			
Blood in urine	yes	no		# of hours of sleep per night: _____			
Vaginal infections	yes	no		Diagnosed sleep apnea	yes	no	
Stress urinary incontinence	yes	No		If yes, when? _____			
Prostate infections	yes	no		Actively using oral appliance for mild sleep apnea	yes	no	
Pulmonary Disease				CPAP/BIPAP prescribed	yes	no	
Short of breath on exertion	yes	no		Actively using CPAP/BIPAP	yes	no	
Hay fever	yes	no		Frequent waking at night	yes	no	
Bloody sputum	yes	no		Choking at night	yes	no	
Persistent cough	yes	no		Aspiration/choking	yes	no	
Infection				# of pillows used: _____			
Recurring infections	yes	no		Cardiovascular			
Skin infections	yes	no		Swelling of ankles	yes	no	
Exercise Limitations				Chest pain	yes	no	
Mild	yes	no		Have you had an echocardiogram?	yes	no	
Moderate	yes	no					
Severe	yes	No					

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Weight History (continued)

Supervised Weight Loss Attempts

None of the below apply	
Diet Pills From MD	
Diet Shots From MD/HCG	
Overeaters Anonymous	
Weight Watchers	
Health Management Resources (HMR)	
T.O.P.S.	
Jenny Craig	
New Direction	
Exercise Counseling	
Nutritional Counseling	

None of the below apply	
Supervised Calorie Counting	
Acupuncture	
Psychological Counseling	
Weight Loss Center	
Personal Trainer	
Medifast	
Metrical	
Nutri-System	
Optifast	
Other	

Weight Loss Medications

None of the below apply	
Acutrim	
Adipex-P	
Alli	
Amphetamines	
Anorex	
Belviq	
Benzphetamine	
Contrave	
Dexatrim	
Didrex	
Fastin	
Fenfluramine	
Qsymia	
Herbal Remedies	
Ionamin	
Liraglutide/Victoza/Saxenda	

None of the below apply	
Mazanor	
Meridia	
Metabolife	
Obalan	
Orlistat	
Phentermine	
Phenfen	
Plegine	
Pondimin	
Redux	
Sanorex	
Tenuate	
Wehless	
Xenical	
Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)	
Stomach stapling	
Vertical banded gastroplasty	

Gastric band	
Sleeve gastrectomy	
Other	

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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

Children: How many alive? ____ How many deceased? ____

Please complete the below section if **NOT** adopted.

	Parent(s)		Sibling(s)		Other Relatives <i>cousins, aunts, grandparents, etc.</i>	No Family History	Don't Know
	Mother	Father	Brother	Sister			
Diabetes							
Heart Disease							
Hypertension							
Gallstones							
Obesity							
Sleep Apnea							
Asthma							
Cancer (<i>specify type</i>)							
Depression							
High Cholesterol							
Osteoporosis							
Stroke							
Chemical Dependency							
Alcohol Abuse							
Bipolar disorder							
Anesthesia Problems							
Schizophrenia							

Exercise History

Please place a check in the appropriate box:

Do you track and/or monitor your activity? yes no

If yes, what do you use? (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/pilates/bands, etc.)						
Weight Lifting						
Aerobic						
Other: _____						

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Exercise History (continued)

Physical limitations preventing exercise: *Please circle the appropriate response:*

Hip pain	yes	no	Back pain	yes	no
Knee pain	yes	no	Fatigue	yes	no
Ankle pain	yes	no	Excessive sweating	yes	no
Foot pain	yes	no	Shortness of breath	yes	no

Nutrition History

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

If yes, what do you use? (examples: MyFitnessPal, Spark People, etc.) _____

How often do you track calories or food intake? Daily 2 – 3 times a week 1 time a week or less

How many meals do you eat daily? _____

Do you snack between meals? yes no

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

Food Frequency

Estimated servings per day: 0-3 per day 3-6 per day 6-9 per day 10+ per day

Estimated servings per day:	0-3 per day	3-6 per day	6-9 per day	10+ per day
Soda/sugary drinks/sweet tea/lemonade				
Sweets/deserts/candy				
Fried foods/fast food/chips/pizza				
Dairy products/cheese/etc.				
Carbs/breads/cereal/pasta				
Fruits/veggies				
Proteins				

Eating Behaviors

Chaotic eating patterns/not eating regular meal yes no
 Sleepwalking & eating yes no
(such as waking up to see evidence of food consumed with no memory of having eaten it.)
 Drinking sweetened beverages – pop, kool-aid, etc. yes no
 Emotional/stress eating yes no

Preference snacking on:
 pretzels, chips, starches yes no
 sweets yes no
 large portion sizes yes no

Other Weight Gain Contributing Factors

Decrease in activity after job change	yes <input type="checkbox"/> no <input type="checkbox"/>	Smoking cessation	yes <input type="checkbox"/> no <input type="checkbox"/>
Decreased activity after an injury	yes <input type="checkbox"/> no <input type="checkbox"/>	Weight gain with pregnancy	yes <input type="checkbox"/> no <input type="checkbox"/>
Genetics	yes <input type="checkbox"/> no <input type="checkbox"/>	Yo-yo dieting	yes <input type="checkbox"/> no <input type="checkbox"/>
Medications	yes <input type="checkbox"/> no <input type="checkbox"/>		

Do you currently use or have used any of the following behaviors in the past 6 months to control your weight? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Bingeing and then vomiting | <input type="checkbox"/> Excessive/obsessive calorie restriction/fasting ('anorexia') |
| <input type="checkbox"/> Bingeing followed by food restriction | <input type="checkbox"/> Excessive/obsessive exercise |
| <input type="checkbox"/> Vomiting purposefully after eating ('bulimia') | <input type="checkbox"/> Laxative abuse |

If any above, when and how long was this period of behavior? _____

Current Eating:

Do you eat large meals in one sitting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how frequent? _____
Do you frequently skip meals, or eat only 1-2 times per day?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how frequent? _____
Do you "graze" or snack frequently throughout the day/evening?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how frequent? _____
Do you eat or snack late in the evening or at night?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how frequent? _____

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Check ONLY ONE statement under each question that best describes the way you feel on a typical day.

TYPICAL DAILY INTAKE

Please record the typical types of foods and the amounts you eat on a regular basis (must complete).

	Food Type	Amount Per Meal
Before Breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon snack		
Dinner		
After dinner		
Before Bed		

I feel...

- 0 I don't feel self-conscious about my weight or body size when I'm with others,
 0 Concerned about how I look to others, but it normally does not make me feel disappointed with myself.
 1 I do get self-conscious about my appearance and weight which makes me feel disappointed in myself.
 3 Very self-conscious about my weight and frequently, I feel intense shame and disgust for myself. I try to avoid social contacts because of my self-consciousness.

I feel...

- 0 I don't have any difficulty eating slowly in the proper manner.
 1 Although I seem to "gobble down" foods, I don't end up feeling stuffed because of eating too much.
 2 At times, I tend to eat quickly and then, I feel uncomfortably full afterwards.
 3 I have the habit of bolting down my food, without really chewing it. When this happens I usually feel uncomfortably stuffed because I've eaten too much.

I feel...

- 0 Capable to control my eating urges when I want to.
 1 Like I have failed to control my eating more than the average person.
 3 Utterly helpless when it comes to feeling in control of my eating urges.
 3 Helpless about controlling my eating I have become very desperate about trying to get in control.

I feel...

- 0 I don't have the habit of eating when I'm bored.
 0 I sometimes eat when I'm bored, but often I'm able to "get busy" and get my mind off food.
 0 I have a regular habit of eating when I'm bored, but occasionally, I can use some other activity to get my mind off eating.
 2 I have a strong habit of eating when I'm bored. Nothing seems to help me break the habit.

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Nutrition History (continued)

*Check **ONLY ONE** statement under each question that **best describes** the way you feel on a typical day.*

I feel...

- 0 I'm usually physically hungry when I eat something.
- 1 Occasionally, I eat something on impulse even though I'm really not hungry.
- 2 I have the regular habit of eating foods, that I might not really enjoy, to satisfy a hungry feeling even though physically, I don't need the food.
- 3 Even though I'm not physically hungry, I get a hungry feeling in my mouth that only seems to be satisfied when I eat a food, like a sandwich, that fills my mouth. Sometimes when I eat the food to satisfy my mouth hunger, I then spit the food out so I won't gain weight.

I feel...

- 0 I don't feel any guilt or self-hate after I overeat.
- 1 After I overeat, occasionally I feel guilt or self-hate.
- 3 Almost all the time I experience strong guilt or self-hate after I overeat.

I feel...

- 0 I don't lose control of my eating when dieting even after periods when I overeat.
- 2 Sometimes when I eat a "forbidden food" on a diet, I feel like I "blew it" and eat even more.
- 3 Frequently, I have the habit of saying to myself, "I've blown it now, why not go all the way" when I overeat on a diet. When this happens I eat even more.
- 3 I have a regular habit of starting strict diets for myself, but I break the diets by going on an eating binge. My life seems to be either a "feast" or "famine."

I feel...

- 0 I rarely eat so much food that I feel uncomfortably stuffed afterwards
- 1 Usually about once a month, I eat such a quantity of food, I end up feeling very stuffed.
- 2 I have regular occurrences during the month when I eat large amounts of food, either at mealtime or at snacks.
- 3 I eat so much food that I regularly feel quite uncomfortable after eating and sometimes a bit nauseous.

I feel...

- 0 My level of caloric intake does not go up very high or go down very low on a regular basis.
- 1 Sometimes after I overeat, I will try to reduce my caloric intake to almost nothing to compensate for excess calories I've eaten.
- 2 I have a regular habit of overeating during the night. It seems my routine is not to be hungry in the morning, but I overeat in the evening.
- 3 In my adult years, I have had week-long episodes where I practically starve myself. This follows episodes of overeating. It seems I live a life of either "feast" or "famine."

I feel...

- 0 I am usually able to stop eating when I want to. I know when "enough is enough."
- 1 Every so often, I experience a compulsion to eat which I can't seem to control.
- 2 Frequently, I experience strong urges to eat which I seem unable to control, but at other times I can control my eating urges.
- 3 I feel incapable of controlling urges to eat. I have a fear of not being able to stop eating voluntarily.

*Check **ONLY ONE** statement under each question that **best describes** the way you feel on a typical day.*

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I feel...

- 0 I don't have any problem stopping eating when I feel full.
- 1 I usually can stop eating when I feel full but occasionally overeat leaving me feeling uncomfortably stuffed.
- 2 I have a problem to stop eating once I start and usually I feel uncomfortably stuffed after I eat a meal.
- 3 Because I have a problem not being able to stop eating when I want, I sometimes have to induce vomiting to relieve my stuffed feeling.

I feel...

- 0 I seem to eat just as much when I'm with others (family, social gatherings) as when I'm by myself.
- 1 Sometimes, when I'm with other persons, I don't eat as much as I want to eat because I'm self-conscious about my eating.
- 2 Frequently, I eat only a small amount of food when others are present, because I am very embarrassed about my eating.
- 3 I feel so ashamed about overeating that I pick times to overeat when I know no one will see me. I feel like a "closet eater."

I feel...

- 0 I eat three meals a day with only an occasional between meal snack.
- 0 I eat three meals a day, but I also normally snack between meals.
- 2 When I am snacking heavily, I get in the habit of skipping regular meals.
- 3 There are regular periods when I seem to be continually eating, with no planned meals.

I feel...

- 0 I don't think much about trying to control unwanted eating urges.
- 1 At least some of the time, I feel my thoughts are pre-occupied with trying to control my eating urges.
- 2 I feel that frequently I spend more time thinking about how much I ate or about trying not to eat anymore.
- 3 It seems to me that most of my waking hours are pre-occupied by thoughts about eating or not eating. I feel like I'm constantly struggling not to eat.

I feel...

- 0 I don't think about food a great deal.
- 1 I have strong cravings for food but they only last for brief periods of time.
- 2 I have days when I can't seem to think about anything else but food.
- 3 Most days seem to be preoccupied with thoughts about food. I feel like I live to eat.

I feel...

- 0 I usually know whether or not I'm physically hungry. I take the right portion of food to satisfy me.
- 1 Occasionally, I feel uncertain about knowing whether or not I'm physically hungry. At these times it's hard to know how much food I should take to satisfy me.
- 2 Even though I might know how many calories I should eat, I don't have any idea what is a "normal" amount of food for me.

Gormally J, Black S, Datson S, Rardin D. The assessment of binge eating severity among obese persons. Addictive Behaviors. 1982;7:47-55