

PERSONAL PROFILE					
TITLE: MR / MRS / MS / MISS / DR		FIRST NAME		LAST NAME	
ADDRESS			CITY	PROVINCE/STATE	
POSTAL/ZIP CODE	HOME PHONE		BUSINESS PHONE		
MOBILE	EMAIL		OCCUPATION		
DATE OF BIRTH: MONTH	DAY	YEAR	SEX:	MALE	FEMALE

IN CASE OF EMERGENCY: NAME		RELATIONSHIP			
ADDRESS:		HOME PHONE:	BUSINESS PHONE:		

FAMILY PHYSICIAN:		ADDRESS		PHONE NUMBER	
OTHER SPECIALISTS YOU ARE CURRENTLY SEEING:					
PHYSICIAN NAME		SPECIALTY		ADDRESS	
PHONE NUMBER					

I AM PRIMARILY INTERESTED IN:					
LAPAROSCOPIC ADJUSTABLE BANDING		LAPAROSCOPIC SLEEVE GASTRECTOMY		LAPAROSCOPIC GASTRIC BYPASS	
REFERRAL INFORMATION		FRIEND REFERRAL		ONLINE	
PHYSICIAN REFERRAL		NAME		NAME	
NAME		NAME		NAME	

SOCIAL PROFILE					
MARITAL STATUS:					
SINGLE	PARTNER/RELATIONSHIP	MARRIED	DIVORCED	SEPARATED	WIDOWED
NUMBER OF CHILDREN:	AGE OF YOUR YOUNGEST CHILD:	WILL YOU BE TRAVELING ALONE FOR YOUR PROCEDURE:		YES	NO
IF NO, WHO WILL BE TRAVELING WITH YOU:					
NAME:		RELATIONSHIP:		MOBILE PHONE:	



MEDICAL INFORMATION

HEIGHT IN FEET/INCHES	FT	"	CURRENT WEIGHT IN POUNDS	LBS	GOAL WEIGHT IN POUNDS	LBS	BMI (OFFICE USE)
OR:			OR:		OR:		
HEIGHT IN METRES		M	CURRENT WEIGHT IN KILOGRAMS	KGS	GOAL WEIGHT IN KILOGRAMS	KGS	BMI (OFFICE USE)

PLEASE CHECK ALL THAT APPLY:

CARDIOVASCULAR

- HEART CONDITIONS (REQUIRING MEDICATION)
- HEART MURMUR
- RACING HEART/SKIPPING BEATS
- TIGHTNESS IN CHEST
- SHORTNESS OF BREATH
- SHORTNESS OF BREATH WHILE EXERCISING
- HIGH CHOLESTEROL (REQUIRING MEDICATION)
- HIGH TRIGLYCERIDES (REQUIRING MEDICATION)

METABOLIC/ENDOCRINE

- DIABETES TYPE 1
- DIABETES TYPE 2
- DO YOU HAVE ANY COMPLICATIONS OF DIABETES?
 - POOR CIRCULATION
 - KIDNEY DAMAGE
 - EYE PROBLEMS
 - PERIPHERAL NEUROPATHY
 - OTHER
- PRE-DIABETIC: (ABNORMAL GLUCOSE TOLERANCE TEST)
- GESTATIONAL: AGE OF DIAGNOSIS?
- HYPOGLYCEMIA
- THYROID PROBLEMS (REQUIRING MEDICATION)
- POLYCYSTIC OVARIAN SYNDROME (PCOS)

RESPIRATORY

- ASTHMA: DATE OF LAST ATTACK:
- BRONCHITIS
 - RECURRING: YES NO
 - NUMBER OF TIMES IN PAST 2 YEARS
- PNEUMONIA
- BLOOD CLOTS IN LUNGS
- SMOKER
 - AGE STARTED?
 - HOW MANY PER DAY?
- SLEEP APNEA
 - CPAP: YES NO

GASTROINTESTINAL

- GALLBLADDER PROBLEMS
- GALLBLADDER REMOVED
- HEARTBURN (STATE FREQUENCY)
 - OCCASIONALLY
 - REGULARLY
 - DAILY
- NOCTURNAL REGURGITATION
 - REQUIRING MEDICATION?: YES NO
- STOMACH ULCERS
 - REQUIRING MEDICATION: YES NO
- PROBLEMS WITH BOWEL FUNCTION
 - CONSTIPATION
 - DIARRHEA
 - OTHER:

NEURO-PSYCHIATRIC:

- DEPRESSION:
 - OBESITY RELATED: YES NO
 - REQUIRING MEDICATION: YES NO
- SEIZURES
 - REQUIRING MEDICATION: YES NO
- SEVERE HEADACHES OR MIGRAINES
 - REQUIRING MEDICATION: YES NO
- SEEING A COUNSELLOR/PSYCHIATRIST
- ALCOHOL DEPENDENCY: # YEARS SOBER:
- DRUG DEPENDENCY :# YEARS CLEAN:
- EATING DISORDERS;

MUSCULOSKELETAL PAIN

- DEGENERATIVE JOINT DISEASE
 - ANTHINFLAMMATORY OR PAIN MEDICATION: YES NO
- SWELLING IN HANDS
- SWELLING IN LEGS
- SWELLING IN FEET
- VARICOSE VEINS
- ULCERS OF THE LEGS
- PROBLEMS WITH LEG VEINS

MEDICATIONS

NAME OF MEDICATION	DOSAGE	TIME OF DAY TAKEN

FAMILY MEDICAL HISTORY				
CONDITION	SIBLINGS/CHILD	PARENTS	OTHER RELATIVES	NO HISTORY
OBESITY				
ARTHRITIS				
DIABETES				
HEART DISEASE				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
CANCER				
BLEEDING/CLOTTING DISORDERS				

SURGICAL HISTORY		
OPERATION	DATE	COMMENT

ALLERGIES			
DRUG	FOOD	OTHER	REACTION

FOR FEMALE PATIENTS		
PROBLEMS CONCEIVING	IRREGULAR MENSTRUAL PERIODS	PAIN DURING MENSTRUAL PERIODS



WEIGHT HISTORY

	BELOW AVERAGE	AVERAGE	HEAVY	OBESE
UNDER 10 YEARS OLD				
10 – 20 YEARS OF AGE				
IN YOUR 20'S				
IN YOUR 30'S				
IN YOUR 40'S				
IN YOUR 50'S				

AT WHAT AGE DID YOU FIRST START HAVING PROBLEMS WITH YOUR WEIGHT?

WAS THERE A SPECIFIC EVENT THAT LED YOU TO GAIN WEIGHT?

YES

NO

PLEASE EXPLAIN:

PLEASE LIST ANY DIETS YOU HAVE TRIED IN THE PAST

NAME OR DESCRIPTION	SUPERVISED	NON SUPERVISED	MEDICATION



ANESTHESIA

	YES	NO	NOT SURE
HAVE YOU EVER HAD AN ABNORMAL REACTION TO GENERAL OR LOCAL ANESTHETIC?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAS ANYONE IN YOUR FAMILY HAD AN ABNORMAL REACTION TO GENERAL OR LOCA ANESTHETIC?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD A REACTION TO A DRUG OR MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD ITCHING, RASH OR WHEEZING AFTER WEARING LATEX GLOVES OR BLOWING UP A BALLOON?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, HAVE YOU EVER HAD A REACTION TO THE BLOOD YOU RECEIVED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE A HEART MURMUR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD RHEUMATIC FEVER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD TUBERCULOSIS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD JAUNDICE? IF SO, WHEN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD HEPATITIS B OR C? IF YES, WHEN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER TAKEN PREDNISONE OR CORTISONE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY FALSE TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY CAPPED TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY LOOSE TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU SMOKE? IF YES, HOW MANY PACKS PER DAY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU COUGH OR HAVE SPUTUM FROM SMOKING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAE EPILEPSY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER HAD A CONVULSION OR SEIZURE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WEAR CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU DRINK ALCOHOL? IF YES, HOW MUCH AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF FEMALE, ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE STATE AND DESCRIBE ANY MAJOR ILLNESSES YOU'VE HAD?

DO YOU OR HAVE YOU TAKEN IN THE PAST ANY MEDICATINE FOR BREATHING AND/OR LUNG PROBLEMS?

WHAT MEDICAINE OR PILLS HAVE YOU TAKEN IN THE LAST YEAR FOR ALLERGIES, ARTHRITIS OR RHEUMATISM?

HAVE YOU EVER BEEN UNDER THE CARE OF A HEART AND/OR LUNG SPECIALIST? YES NO

I CERTIFY THAT ALL THE INFORMATION ABOVE IS CORRECT YES NO