Premier Weight Loss Solutions
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Premierweightlosssolutions.com

Name: _____ DOB: _____

You current Height: _____ Your current weight: _____

Have you had previous bariatric surgery? □ Yes □ No

If yes, what surgery: _____

Are you interested bariatric surgery? □ Yes □ No

If yes, what surgery: _____

Physician Care Information

Specialty	Name	Phone Number
Primary Care	_____	_____
Internist	_____	_____
Cardiologist	_____	_____
Pulmonologist	_____	_____
Psychiatrist/Psychologist	_____	_____
Gynecologist/Urologist	_____	_____
Neurologist	_____	_____
Other_____	_____	_____

Current Medication List

Please include all prescriptions, over the counter medications, supplements, herbs, and vitamins.

□ If you have attached a list, please check here

Name	Dosage/Units	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____ DOB: _____

Medication & Substance Allergies

- ☐ No Known Drug Allergies (NKDA)
- ☐ Latex Allergy Reaction_____
- ☐ Iodine Allergy Reaction_____
- ☐ IV Contrast allergy Reaction_____
- ☐ Adhesive Allergy Reaction_____
- ☐ Drug Allergies: _____ Reaction_____
- ☐ Drug Allergies: _____ Reaction_____
- ☐ Drug Allergies: _____ Reaction_____
- ☐ Other Allergies: _____ Reaction_____
- ☐ Other Allergies: _____ Reaction_____

Past Surgical History

Surgery	Year	Hospital	Physician

Other Hospitalizations: (non-surgical ex: psychological, injury, disease)

Illness	Year	Hospital	Physician

Have you ever experienced any of the following?

- ☐ Blood Clots
- ☐ Abnormal Bleeding
- ☐ Problems with Anesthesia If yes please explain: _____
- ☐ Difficulty Healing If yes please explain: _____

Name: _____ DOB: _____

History of Diet Programs

Please check if you have tried any of the following diet plan/programs/pills:

	Program	Date	Weight (lost or gained)	Length of Participation
☐	Acutrim	_____	_____	_____
☐	Atkins	_____	_____	_____
☐	Bariatric Surgery	_____	_____	_____
☐	Binging/Purging	_____	_____	_____
☐	Cabbage Soup	_____	_____	_____
☐	Calorie Counting	_____	_____	_____
☐	Contrave	_____	_____	_____
☐	Dexatrim	_____	_____	_____
☐	Exercise/GYM program	_____	_____	_____
☐	Fasting	_____	_____	_____
☐	Fen-Phen	_____	_____	_____
☐	Health Spa	_____	_____	_____
☐	Herbal Life	_____	_____	_____
☐	High Protein	_____	_____	_____
☐	Hypnotism	_____	_____	_____
☐	Jenny Craig	_____	_____	_____
☐	LA Weight loss	_____	_____	_____
☐	Low Carb	_____	_____	_____
☐	Low Fat	_____	_____	_____
☐	Mayo Clinic	_____	_____	_____
☐	Meridia	_____	_____	_____
☐	Nutri System	_____	_____	_____
☐	Opti-Fast/Medi-Fast	_____	_____	_____
☐	Over Eater Anonymous	_____	_____	_____
☐	Physician Supervised Diets	_____	_____	_____
☐	Prozac	_____	_____	_____
☐	Qsymia	_____	_____	_____
☐	Redux	_____	_____	_____
☐	Richard Simmons	_____	_____	_____
☐	Saxenda	_____	_____	_____
☐	Slim Fast	_____	_____	_____
☐	South Beach	_____	_____	_____
☐	Sugar Busters	_____	_____	_____
☐	Topamax	_____	_____	_____
☐	TOPS	_____	_____	_____
☐	Wegovy	_____	_____	_____
☐	Weight Watchers	_____	_____	_____
☐	Wellbutrin	_____	_____	_____
☐	Xenical	_____	_____	_____
☐	Zone	_____	_____	_____
☐	Other_____	_____	_____	_____

Name: _____ DOB: _____

Dietary and Lifestyle Assessment

Please answer all questions about your current and/or past history. Mark an X beside your answer for every question.

PATIENT:	**YES**	**NO**	**Notes**
Is Lactose Intolerant:	_____	_____	_____
Has Religious/Cultural Food Practices:	_____	_____	_____
Has Food Allergies/Sensitivities:	_____	_____	_____
Eats Out Frequently:	_____	_____	_____
Grocery Shops/Meal Preps on Own?	_____	_____	_____

PATIENT REPORTS:	**YES**	**NO**	**Notes**
Consistently Skipping Meals	_____	_____	_____
Eating Fried Foods Frequently	_____	_____	_____
Eating Sweets/Desserts Frequently	_____	_____	_____
Being a Fast Eater	_____	_____	_____
Binging/Feeling Out of Control w/ Food	_____	_____	_____
Grazing/Lack of Structure When Eating	_____	_____	_____
Night Eating	_____	_____	_____
Emotional Eating/Eating When Bored	_____	_____	_____
Large Portions are Needed to Feel Full	_____	_____	_____

PHYSICAL ACTIVITY:	**WEEKLY**	**RARELY**	**NOT AT ALL**	**Notes**
Exercise	_____	_____	_____	_____

SUPPORT: **Notes**

Patient's Support System with Weight Loss Looks Like _____

GOALS: **Notes**

Weight _____

Health Improvements from Weight Loss _____

Social Assessment

Do you currently use tobacco products/nicotine? ☐ Yes or ☐ No or ♈ Never

Have you used tobacco products/nicotine in the past? ☐ Yes or ☐ No

If Yes, type of tobacco/nicotine:

☐ Cigarettes/ _____ packs per day
☐ Chewing tobacco
☐ Smokeless tobacco
☐ Vaping

Tobacco/nicotine (frequency):

☐ Rare (1-2 times/month) ☐ Occasionally (3 or less/week) ☐ Frequently (4+ /week or daily)

Have you quit using tobacco products/nicotine? ☐ Yes or ☐ No

If yes, what/when was your quit date? _____

Name: _____ DOB: _____

Do you use alcohol? □ Yes or □ No or ♈ Never

If yes, what type? _____

Alcohol use (frequency):

□ Rare (1-2 times/month) □ Occasionally (3 or less/week) □ Frequently (4+ /week or daily)

Do you recreationally use drugs/medications/substances? □ Yes or □ No or ♈ Never
(ex. Marijuana, Cocaine, Ecstasy, Heroin, prescription drugs, etc.)

Have you used in the past? □ Yes or □ No

If yes, what type? _____

Recreational drug use (frequency):

□ Rare (1-2 times/month) □ Occasionally (3 or less/week) □ Frequently (4+ /week or daily)

Have you quit using recreational drug(s)? □ Yes or □ No

If yes, what/when was your quit date? _____

Do you live alone? □ Yes or □ No

Occupation: _____

Disability Information

- □ Check here if you are disabled
  Year of disability: _____
  Type of disability: _____ (accident, illness, work injury, etc.)
- Do you require assisted devices? ___ Cane ___ Walker ___ Crutches
- Do you require a wheelchair or a motorized scooter? □ YES or □ NO

Family Medical History Assessment

Please mark any conditions that have been diagnosed in biological relation(s) such as parents, grandparents, siblings. Please check all that apply:

- □ Family History Unknown
- □ Arthritis
- □ Bleeding
- □ Cancer
- □ Diabetes
- □ Blood Clots
- □ Heart Attack
- □ Heart Disease
- □ High Cholesterol
- □ Hypertension
- □ Obesity
- □ Renal Failure
- □ Stroke
- □ Other

Name: _____ DOB: _____

Past Medical History Assessment

Please answer all questions about your current and/or past history. Mark an X beside Yes or No for every question.

CARDIOVASCULAR	**YES**	**NO**	**Notes**
Abnormal Heart Rhythms	_____	_____	_____
Angina/Chest Pain	_____	_____	_____
Blood Clot in Leg or Lung	_____	_____	_____
Congestive Heart Failure	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Catheterization	_____	_____	_____
Heart Palpitations	_____	_____	_____
Heart Stress Test	_____	_____	_____
Heart Valve Abnormality	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Implantable Defibrillator	_____	_____	_____
Ischemic Heart Disease	_____	_____	_____
Lower Leg Edema/Swelling	_____	_____	_____
Pacemaker	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Stents Placed in Heart	_____	_____	_____
Vena Cava heart filter	_____	_____	_____

ENDOCRINE	**YES**	**NO**	**Notes**
Cushing's	_____	_____	_____
Diabetes Mellitus, Type 1	_____	_____	_____
Diabetes Mellitus, Type 2	_____	_____	_____
Endocrine Tumors	_____	_____	_____
Eye/Kidney Problems	_____	_____	_____
Fasting Glucose > 99mg/dL	_____	_____	_____
Gout/High Uric Acid Levels	_____	_____	_____
Insulin Use	_____	_____	_____
Oral Medication for Diabetes	_____	_____	_____
Polycystic Ovarian Syndrome	_____	_____	_____
Thyroid Cancer	_____	_____	_____
Hypo or Hyper Thyroid	_____	_____	_____

PULMONARY	**YES**	**NO**	**Notes**
Asthma	_____	_____	_____
COPD	_____	_____	_____
Emphysema	_____	_____	_____
Inhaler Use Due to Asthma	_____	_____	_____
Oxygen Use at Home	_____	_____	_____
Previous Sleep Study	_____	_____	_____
Pulmonary Embolism	_____	_____	_____
Pulmonary Hypertension	_____	_____	_____
Sleep Apnea	_____	_____	_____

- How many blocks can you walk without getting short of breath _____

Name: _____ DOB: _____

GASTROINTESTINAL	**YES**	**NO**	**Notes**
Abdominal Hernia	_____	_____	_____
Abnormal Liver Tests/Fatty Liver	_____	_____	_____
Barrett's Esophagus	_____	_____	_____
Chronic Constipation	_____	_____	_____
Cirrhosis of the Liver	_____	_____	_____
Crohn's Disease or Colitis	_____	_____	_____
Difficulty Swallowing Foods/Liquids	_____	_____	_____
Gallbladder Removal	_____	_____	_____
Gallstones	_____	_____	_____
Heartburn Medication use	_____	_____	_____
Heartburn/Reflux/GERD	_____	_____	_____
Hepatitis	_____	_____	_____
Hernia Repair	_____	_____	_____
Hiatal Hernia	_____	_____	_____
History of Gastrointestinal Cancer	_____	_____	_____
Pancreatitis	_____	_____	_____
Past Anti-Reflux Surgery	_____	_____	_____
Past Colonoscopy	_____	_____	_____
Past Upper Gastrointestinal X-Ray	_____	_____	_____

MUSCULOSKELETAL	**YES**	**NO**	**Notes**
Back Pain Requiring Medication	_____	_____	_____
Back Pain	_____	_____	_____
Back Surgery	_____	_____	_____
Fibromyalgia	_____	_____	_____
Hip/Knee/Ankle Pain	_____	_____	_____
Joint Pain Requiring Medication	_____	_____	_____
Joint Replacement	_____	_____	_____

REPRODUCTIVE (female)	**YES**	**NO**	**Notes**
Hysterectomy	_____	_____	_____
Infertility	_____	_____	_____
Menopause	_____	_____	_____
Menstrual Irregularities	_____	_____	_____
Polycystic Ovarian Syndrome	_____	_____	_____
Pregnancies	_____	_____	_____
Pregnancy Complications	_____	_____	_____

- How many Pregnancies _____ How many delivered _____ How many C-Sections _____

GENERAL	**YES**	**NO**	**Notes**
Cane or Walker use	_____	_____	_____
Glaucoma	_____	_____	_____
HIV	_____	_____	_____
Kidney Disease	_____	_____	_____
Kidney Stones	_____	_____	_____
Lupus/Autoimmune Disease/RA	_____	_____	_____
MRSA/VRE	_____	_____	_____
Pseudotumor Cerebri	_____	_____	_____
Sores/Rash in Skin Folds	_____	_____	_____
Stress Urinary Incontinence	_____	_____	_____

Name: _____ DOB: _____

PSYCHOSOCIAL	**YES**	**NO**	**Notes**
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Bipolar Disease	_____	_____	_____
Thoughts of Suicide	_____	_____	_____
Suicide Attempts	_____	_____	_____
Psychiatric Treatment	_____	_____	_____
Psychological Counseling	_____	_____	_____
Hospitalized for Psychological Issues	_____	_____	_____
Schizophrenia	_____	_____	_____
Anorexia	_____	_____	_____
Bulimia	_____	_____	_____
Binge Eating	_____	_____	_____

NEUROLOGY	**YES**	**NO**	**Notes**
Migraines	_____	_____	_____
Mini Stroke/TIA	_____	_____	_____
Numbness/Tingling	_____	_____	_____
Seizures	_____	_____	_____
Stroke	_____	_____	_____

BLOOD/CLOTTING	**YES**	**NO**	**Notes**
Anemia	_____	_____	_____
Clotting/Platelet Disorder/Factor V	_____	_____	_____
Deep Vein Thrombosis	_____	_____	_____
Sickle Cell	_____	_____	_____

- ❖ Are you willing to accept blood transfusions? ☐ Yes or ☐ No
- ❖ Are you taking a blood thinner? ☐ Yes or ☐ No
  - ☐ Aspirin
  - ☐ Coumadin
  - ☐ Eliquis
  - ☐ Heparin
  - ☐ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
  - ☐ Plavix
  - ☐ Pradaxa
  - ☐ Xarelto