Weight Management
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Owensboro Health

Patient Name: _____ Date of Birth: _____

Drug allergies: _____ Pharmacy: _____

Marital status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino

Preferred Language: ❒ English ❒ Spanish ❒ Other _____

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ Black/African American
❒ Native Hawaiian ❒ Other Pacific Islander ❒ White

Patient Medical History

Place a ☐ mark next to all positive responses

❒ Heart attack
❒ Osteoporosis
❒ Seizures
❒ Stroke
❒ High Blood Pressure
❒ Bleeding problems
❒ Kidney disease
❒ Ulcers
❒ Vascular disease
❒ Breathing problems
❒ Anemia
❒ Gout
❒ Sickle cell anemia
❒ Breast cancer
❒ Colon cancer
❒ Lung cancer
❒ Prostate cancer
❒ Skin cancer
❒ Other cancer
❒ Ovarian cancer
❒ Nerve/muscle disease
❒ GERD/Reflux
❒ Blood transfusion
❒ HIV/AIDS
❒ Thyroid disease
❒ Diabetes
❒ Clotting disorder
❒ Sleep apnea
❒ Arthritis
❒ Pancreatitis
❒ Migraine
❒ Kidney stones
❒ Medullary Thyroid Carcinoma
❒ Endocrine Carcinoma

Other:
_____
_____
_____
_____
_____
_____

Patient Surgical History

Place a ☐ mark next to all positive responses

❒ Appendectomy
❒ Breast surgery
❒ Tubal ligation
❒ Colon surgery
❒ C-section
❒ Prostate surgery
❒ Heart surgery
❒ Gallbladder
❒ Colonoscopy
❒ Small intestine surgery
❒ Hernia repair
❒ Hysterectomy
❒ Upper Scope (EGD)
❒ Tonsilectomy
❒ Bariatric Surgery
❒ Vein procedure
❒ Other surgeries? (List below)

_____
_____
_____

Family History

Indicate family members with the following condition(s) by placing a ☐ mark in the column

Relationship	Deceased	Alive	Anesthesia problems	Bleeding disorder	Coronary artery Disease	Cancer	Breast cancer	Colon cancer	Lung cancer	Prostate cancer	Ovarian cancer	Skin cancer	Stomach cancer	Thyroid cancer	Diabetes	Heart attack	Heart defect	Heart disease	Immunodeficiency	Lung disease	Lupus	Endocrine Carcinoma	Stroke	Thyroid disease	High blood pressure
Mother																									
Father																									
Sister																									
Brother																									

Social History

Alcohol use ❒ No ❒ Rarely ❒ Moderate ❒ Daily
Tobacco use ❒ Current smoker, packs per day_____ ❒ Years?_____ ❒ Former Smoker ❒ Never
Marijuana use ❒ No ❒ Rarely ❒ Moderate ❒ Daily

☐ all that apply ❒ Cigarettes ❒ Cigars ❒ Pipe

Smokeless tobacco ❒ No ❒ Yes ❒ Chewing Tobacco ❒ Snuff
Drug use ❒ No ❒ Yes

Obstetrical History

Pregnancy ❒ No ❒ Yes Number?_____
Miscarriage ❒ No ❒ Yes Number?_____

Have you had any of the following during the past three months? ☐ all that apply

Constitutional

- ❒ Recent weight loss
- ❒ Recent weight gain
- ❒ Fever
- ❒ Fatigue
- ❒ Chills
- ❒ Night sweats

Eyes

- ❒ Eye disease or injury
- ❒ Blurred or double vision
- ❒ Sudden change in vision

ENT

- ❒ Hearing loss
- ❒ Ringing in the ears
- ❒ Earaches or drainage
- ❒ Sinus problems
- ❒ Nose bleeds
- ❒ Mouth sores
- ❒ Bleeding gums
- ❒ Bad breath or bad taste
- ❒ Sore throat or voice change (hoarseness)
- ❒ Swollen glands in neck

Cardiovascular

- ❒ Heart trouble
- ❒ Chest pains
- ❒ Sudden heart beat changes
- ❒ Swelling of feet, ankles, or hands

Respiratory

- ❒ Frequent coughing
- ❒ Spitting up blood
- ❒ Shortness of breath
- ❒ Asthma or wheezing

Gastrointestinal

- ❒ Loss of appetite
- ❒ Change in bowel movements
- ❒ Nausea or vomiting
- ❒ Frequent diarrhea
- ❒ Painful bowel movements or constipation
- ❒ Red blood in stool
- ❒ Stomach pain
- ❒ Black tarry bowel movements
- ❒ Clay(light) colored stool
- ❒ Food intolerance
- ❒ Difficulty swallowing
- ❒ Yellow jaundice
- ❒ Heartburn

Genitourinary

- ❒ Frequent urination
- ❒ Burning with urination
- ❒ Painful urination
- ❒ Blood in urine
- ❒ Change of force or strain when urinating
- ❒ Incontinence or dribbling
- ❒ Sexual difficulty
- ❒ Testicle pain

Gynecology

- ❒ Irregular periods
- ❒ Vaginal discharge
- ❒ Painful periods

Musculoskeletal

- ❒ Joint pain
- ❒ Joint stiffness or swelling
- ❒ Weakness of muscles or joints
- ❒ Muscle pain or cramps
- ❒ Back pain
- ❒ Cold extremities
- ❒ Difficulty in walking

Skin

- ❒ Rash or itching
- ❒ Change in hair or nails
- ❒ Varicose veins
- ❒ Breast pain
- ❒ Breast lump
- ❒ Breast discharge

Have you had any of the following during the past three months? ☐ all that apply

Neurological

- ❐ Frequent or recurring headaches
- ❐ Numbness or tingling sensation
- ❐ Light headed or dizzy
- ❐ Paralysis

Psychiatric

- ❐ Memory loss or confusion
- ❐ Depression
- ❐ Nervousness
- ❐ Sleep problems

Endocrine

- ❐ Excessive thirst or urination
- ❐ Heat or cold intolerance

Hematologic/Lymphatic

- ❐ Easily bruise or bleed
- ❐ Blood clots
- ❐ Anemia
- ❐ Enlarged glands

Have you had lab work in the past 3 months ❐ Yes Where?____________________

Have you had an EKG or chest x-ray in the past 6 months? Where: ____________________

Have you ever had an adverse reaction to anesthesia? ❐ Yes What were your symptoms?____________________

____

Medications

Name of medication(s) you are currently taking:	Dose?	Frequency?