Surgical Weight Loss Center
2235 Mayfair Avenue
Owensboro, KY 42301
Phone (270) 688-1500
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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

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
- ☐ Vein procedure
- ☐ Other surgeries? (List below)

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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	Osteoporosis	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

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

Eyes

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

ENT

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Genitourinary

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

Gynecology

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

Musculoskeletal

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

Skin

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

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Medications

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