UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER™
DEPARTMENT OF SURGERY

Surgical Weight Loss Questionnaire

Name: ____

DOB: _________________ Age: ___________ Gender: Male _____ Female_____

Height: _____ (feet) _____ (inches) Weight: __________ (lbs)

Marital status ____________ Currently employed as a ______________________

Number and ages of children ____

____

Name of Referring Physician ____

Address of Physician ____

Phone number of Physician ____

Weight History:

Life Event	Age	Weight
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 years		
Highest Weight in Past 5 year		

List all Allergies and type of reaction... ______________________________________

____

Name ____

List the diets and diet programs you have tried:

Program	Year	Duration	MD Supervised	Max Weight Loss
Jenny Craig				
Nutri-Systems				
Weight Watchers				
OptiFast				
Fen/Phen/Redux				
Meridia				
Lindora				
TOPS				
O.A.				
Acupuncture				
Metabolife				
Atkins				
Pritikin				
Physician Supervised				
Other:				

Please list all serious illnesses and hospitalizations you have experienced...

Major Illness/Major Surgery	Date	Treatment

Name ____

Have you had, or do you have, any of the following?

Disease or Symptom	When Diagnosed & Test Done to Diagnose
Cigarette Smoking—how many packs/day?	
Beer, wine, other alcohol—how many/day?	
Marijuana, cocaine or heroin?	
Heart Disease	
Stroke	
High Cholesterol	
High Blood Pressure	
Diabetes	
Asthma	
Shortness of Breath	
Trouble Sleeping	
Sleep Apnea	
Heartburn/Esophagitis/Hiatal Hernia	
Belching up acid or sour fluid	
Coughing or choking at night	
Gallbladder Disease	
Leakage of urine with laughing/coughing/sneezing	
Low back pain/strain/sciatica	
Pain to Hips/Knees/Ankles/Feet	
Blood clot in legs or lungs	
Venous Stasis Disease	
Gout	
Hepatitis	
Thyroid Problems	
Kidney Disease	
Liver Disease	
Depression, Anxiety, Serious Psychiatric Cond.	

Please list all medications you currently use.

Medication	Dose	Frequency

Name ____

List all physicians under whom you receive medical care.

Doctor Name	Specialty	Address	Phone Number

For Female Patients

Number of Pregnancies	Age of first period
Number of live births	Date of Last Period
Miscarriages/Abortions	Tubal Ligation [ ]yes [ ]no
Obstetric Complications	Hysterectomy [ ]yes [ ]no
Type of Birth Control	
Estrogen Replacement Therapy [ ]yes [ ]no	

Family History

Illness	Family Member	Family Member	Family Member
Obesity			
Diabetes			
High Blood Pressure			
Heart Disease			
High Cholesterol			
Lung Disease			
Kidney Disease			
Blood Disorder			
Cancer			
Asthma			

6/07