Patient Health and Information:

Patient Information

First Name:
Last Name:

Date of Birth: Age: Race:
Social Security:
Marital Status:

Address:
City: State: Zip:

Home Phone:
Cell Phone: E-mail:

Insurance Company:
Policy Number: Group Number:
Customer Service/Provider Number:
Insured's Name:
Social Security Number: Date of Birth:

How did you hear about Clifton Thomas, M.D.?

What is your current weight? What is your current height?

Are you interested in:
Gastric Bypass Adjustable gastric banding Gastric Sleeve

List any medical problems you have for which you have been seen a doctor or been hospitalized.

Illness	Date	Treatment	Outcome

Have you been diagnosed or treated for high blood pressure?
Have you been diagnosed or treated for diabetes?
Do you have high blood cholesterol?
Do you have high blood fats or triglycerides?
Have you ever been diagnosed with asthma?
Have you been diagnosed or treated for Heartburn or gastro esophageal reflux?

Have you ever had stomach ulcers?
Have you ever had blood clots in your leg veins?
Have you ever been anemic?
Have you ever had an iron deficiency or taken iron?
Have you ever been diagnosed with Hypothyroidism?
Have you ever had thyroid surgery?
Do you take thyroid replacement medication?

Have you ever had weight loss surgery before?
If yes when and what type of surgery:

Does your religion prohibit you from receiving blood products?
Have you had your gall bladder removed?
Have you had a hysterectomy?
Have you have a tubal ligation or had your “tubes tied”?

List all surgeries and specify of done open or laparoscopically.

Surgery	Date	Reason	Open or laparoscopic

List all current medications: including prescriptions, vitamins, and over the counter medications.

Name	Strength	How often taken	Purpose	Start Date

List any allergies to medication and explain reactions you experienced:

Do you take aspirin on a daily basis?
Do you take Plavix?
Do you take Coumadin?
Do you take Prednisone or Dexamethasone?
Have you ever smoked tobacco products?

_____ If yes, how many years?
_____ How many cigarettes per day/
Do you currently use tobacco products?
_____ If yes, how many perday?

Do you get chest pains when exercising?
Do you get short of breath at rest?
Do you get short of breath when exercising?
Do you experience irregular or excessively strong heartbeats?
Do you sleep lying flat?
Do you wake up at night short of breath?
Have you ever had a black out?
Do you get swollen ankles?
Have you had easy or excessive bleeding from surgery or minor injuries?
Have you had easy bruising?
Do you have heavy periods?
Are you still having periods?

Sleep Apnea Self Test

This quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

(20) _____1. I have been told that I snore or I know that I snore.
(-50) _____2. I definitely do not snore.
(0) _____3. I do not know if I snore.
(10) _____4. I have been told that I stop breathing when I sleep.
(10) _____5. I wake up choking.
(5) _____6. I sweat excessively at night.
(-5) _____7. (if female and above is true) I have hot flashes related to my cycle.
(2) ______8. I am tired and sleepy during the day even after 8 hours of sleep.
(2) ______9. I wake up tired and un rested.
(10) ______10. I suddenly wake up unable to breath.
(5) ______11. I have fallen asleep while driving.
(5) ______12. I am a restless sleeper (toss and turn a lot).
(20) ______13. My neck circumference is more than 17 inches.
(5) ______14. I frequently have morning headaches.

___________ Total (more than 30 points suggest that you have Sleep Apnea.

Do you sleep with a C-Pap or Bi-Pap?

Have you ever received psychiatric treatment?

Diagnosis and reason for treatment?

Last treatment date?

Physicians Name:
Address:
Phone:

Diet History
Please complete this portion as precisely as possible:

M.D. Supervised:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Medi-Fast:				
Opti-Fast:				
Mayo Clinic:				
Physician Diet Program:				

SHOTS:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
B-6:				
B-12				
Other:				

Pills:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Lasix (diuretic):				
Xenical:				
Meridia:				
Other:				

Non M.D. Supervised

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Weight Watchers:				
Nutri-Systems:				
Jenny Craig:				
Diet Center:				

TOPS:
Overeasters Anonymous:
Other:

Liquid Diets:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Slim Fast:				
Sweet Success:				
Liquid Protein:				
Other:				

Miscellaneous Diets:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Low Calorie Diet:				
Low Fat Diet:				
High Protein Diet:				
Self- Imposed Fasts:				
Richard Simmons:				
Herbal Life:				
Cambridge Diet:				
Dr. Atkins Diet:				
Other:				

Diet Pills(over the counter):

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Acutrim:				
Dexatrim:				
Metabolife:				
Xenadrine:				
Other:				

Other Types of Weight Loss:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Psychotherapy:				
Acupuncture:				
Hypnosis:				
Subliminal Tapes:				
Other:				

Exercise:

	#Times Tried	Dates Tried	Length of time on diet	#of Lbs. Lost
Health Club:				
VCR Tapes:				
Other:				

How long have you been over weight? Age first began?
Most weight you have ever lost? How was the weight loss obtained?
Are you a snacker? Favorite Foods?
Do you eat a lot of sweets? How often do you eat sweets a day?
Are you currently under a physicians care for weight loss?

What is your most comfortable weight?
Comparing your current weight to that of 6 months ago, please indicate the amount of weight change to the nearest ½ pound:

________gained ________lost _________no change

I have provided accurate and complete information to the best of my knowledge: (Please type your name)