Ochsner
Surgical Weight Loss Program

Patient Information Worksheet

Date: _____

PATIENT DEMOGRAPHIC INFORMATION

Date of Birth: _____

(Title) First Name Mi Last Name Maiden Name Suffix Nickname

PATIENT 'S PHYSICIAN INFORMATION

Name of primary care physician _____

Address _____

Telephone Number _____ FAX Number _____

Please list any other physicians you are seeing:

A. Physician Name _____ Specialty _____

Address _____

Telephone Number _____ FAX Number _____

B. Physician Name _____ Specialty _____

Address _____

Telephone Number _____ FAX Number _____

C. Physician Name _____ Specialty _____

Address _____

Telephone Number _____ FAX Number _____

D. Physician Name _____ Specialty _____

Address _____

Telephone Number _____ FAX Number _____

E. Physician Name _____ Specialty _____

Address _____

Telephone Number _____ FAX Number _____

MEDICAL HEALTH INFORMATION

PSYCHIATRIC DISORDERS	Yes	No	Year Diagnosed	Comments	Physician
Depression					
Bipolar Depression					
Anxiety					
Schizophrenia					
Eating Disorder					
Other _____					

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PSYCHIATRIC DISORDER (cont.)

Do you currently take medication(s) for depression, anxiety, or other emotional health issue?	☐ Yes ☐ No
Have you ever seen a mental health professional such as a psychiatrist, psychologist, social worker or counselor?	☐ Yes ☐ No
Have you ever participated in psychotherapy or counseling?	☐ Yes ☐ No
Have you ever been hospitalized for psychiatric reasons?	☐ Yes ☐ No
Have you ever felt suicidal or attempted suicide?	☐ Yes ☐ No
Have you ever experienced problems with addiction to alcohol, illicit drugs or prescription medications?	☐ Yes ☐ No
Have you ever experienced hallucinations?	☐ Yes ☐ No
Have you ever had Electroconvulsive Shock Therapy (ECT)?	☐ Yes ☐ No
Is there any family history of psychiatric issues?	☐ Yes ☐ No
Are you on disability for psychiatric reasons?	☐ Yes ☐ No
Do you have any personal or religious preferences regarding the use of blood products?	☐ Yes ☐ No

HEALTH INFORMATION

FAMILY HISTORY

In this section, complete the chart to the best of your knowledge. If adopted and have no history of your biological family, place an X in the box. ☐ Adopted

Family Member	Approximate Weight	Present Age	If Deceased, age at death	If Deceased, list cause of death	List any Medical Problems (eg Heart Disease, Cancer, Diabetes, Hypertension)
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Brother(s)					
Sister(s)					
Half Brother					
Half Sister					

SMOKING, DRUG, ALCOHOL HISTORY

1. Do you currently use tobacco? ☐ Yes ☐ No When did you quit? _____

   If yes: a. What type? ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew / Snuff

   b. How many years have you used tobacco? _____

   c. How much do/did you smoke per day? _____

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SMOKING, DRUG, ALCOHOL HISTORY (cont.)

2. Do you currently or have you ever used any illicit drugs (eg Marijuana, Cocaine, Heroin, Amphetamine, etc.) ☐ Yes ☐ No
   If yes, please explain.
3. Do you currently drink alcohol? ☐ Yes ☐ No
   If yes, how many drinks do you drink per week? _____

SOCIAL HISTORY

Occupation: _____

Work status: ☐ full time ☐ part time ☐ retired ☐ unemployed ☐ sick leave ☐ Other _____

Disability: please indicate cause: _____ Date began _____

What is your current marital status? ☐ married ☐ single ☐ separated ☐ divorced ☐ widowed

MEDICATION INFORMATION

Please list all prescribed and over the counter medications that you are currently using.

Medication	Dose	Times Per Day	Year Started on Meds	Purpose

PHARMACY INFORMATION

Name of Pharmacy _____

Address _____

Telephone Number _____

ALLERGY INFORMATION

Please list any known food / drug allergies	What allergic reaction did you have?	Was it?
		☐ mild ☐ moderate ☐ severe
		☐ mild ☐ moderate ☐ severe
		☐ mild ☐ moderate ☐ severe
		☐ mild ☐ moderate ☐ severe
		☐ mild ☐ moderate ☐ severe
Latex allergy? ☐ yes ☐ no		☐ mild ☐ moderate ☐ severe

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THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze off 1 = *slight* chance of dozing 2 = *moderate* chance of dozing 3 = *high* chance of dozing

Situation	Chance of dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (eg theater or meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when the circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____

Thank you for taking the time to fill out this questionnaire. Please bring it with you to your consultation.

_____

Patient Signature