

# Patient Profile

## Personal Information



Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Ethnic Group:   Caucasian \_\_\_\_\_                      African American \_\_\_\_\_                      Asian  
                          Hispanic \_\_\_\_\_                      American Indian \_\_\_\_\_                      Other

**Make corrections to the following information if it has changed since you sent in your Demographic Form.**

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone:       (Home) \_\_\_\_\_                      (Work) \_\_\_\_\_

Cellular #: \_\_\_\_\_ Beeper #: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status:                      Never Married \_\_\_\_\_                      Married \_\_\_\_\_                      Divorced  
                                                  Widowed \_\_\_\_\_                      Separated \_\_\_\_\_

Spouses Name: \_\_\_\_\_

## Referral Information

How did you hear about us? Please check all that apply

Physician \_\_\_\_\_ Other Patient \_\_\_\_\_ Newspaper \_\_\_\_\_ Magazine  
Yellow Pages \_\_\_\_\_ Television \_\_\_\_\_ Our Web Site \_\_\_\_\_ Internet

Referring Doctor: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Contact Person(s)

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not update our office.

NEXT OF KIN (NOT LIVING WITH YOU)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: Home: (    ) \_\_\_\_\_ Work: (    ) \_\_\_\_\_

**Occasionally it is beneficial to you for Lafayette General Bariatric's Department to discuss your confidential information with others such as spouse, partner, family member, etc.**

\_\_\_\_\_ I do not authorize Lafayette General Bariatrics to discuss my confidential information.  
Initial

\_\_\_\_\_ I authorize Lafayette General Bariatrics to discuss my confidential information with  
Initial

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

# Physicians

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Psychologist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Pulmonologist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Endocrinologist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Orthopedic Surgeon: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Other: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Weight and Weight Loss History

Height:      ft. \_\_\_\_\_      in. \_\_\_\_\_      Weight: \_\_\_\_\_

Age of obesity onset:

\_\_\_\_\_ 0-2 years old      \_\_\_\_\_ 12-18 years old      \_\_\_\_\_  
\_\_\_\_\_ 2-12 years old      \_\_\_\_\_ Young Adult      \_\_\_\_\_

How many years have you been at your present weight ? \_\_\_\_\_

Greatest single weight loss: \_\_\_\_\_ pounds

Weight loss was sustained for: \_\_\_\_\_ months

Were there any particular events that lead to significant weight gain?

\_\_\_\_\_ Loss of a loved one      \_\_\_\_\_ Trauma-accident or illness  
\_\_\_\_\_ Pregnancy      \_\_\_\_\_ Loss of employment

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Detailed Diet History

Fill in the dates you participated in the following diet programs, the **pounds lost, pounds regained** and the **time spent** in each program.

Name of diet program	Dates Followed / Taken		Number of months	Pounds lost
	From	To		
Acupuncture				
Weight Watchers				
Nutrisystem				
Pritikin				
Scarsdale				
Diet Center				
Jenny Craig				
Dexatrim				
Grapefruit Diet				
Rice				
Atkins				
Slim Fast				
O.A.				
Herbal Diets				
Hypnosis				
Tops				
Teeth Wiring				
Calorie Counting				
Richard Simmons				
Exercising				
Low Fat				
Cabbage Diet				
American Heart Association				
Radar Institute				
Duke University Programs				
Structure House				
Inpatient Psychiatric Programs				
Outpatient Psychiatric Programs				
Optifast				
Carefast				
Medifast				
Meridia				
Xenical				
Fastin				
Ionamin				
Phenteramine/Fenfluramine				
Redux				
Other:				

Details of any other weight loss measures (including surgical):

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Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

# Surgical History

Please indicate with a check any of the following surgeries you have had and indicate the year of the surgery

TYPE OF SURGERY	HAD SURGERY	YEAR
Adenoidectomy		
Angioplasty		
Ankle Surgery		
Appendectomy		
Back Surgery		
Breast Augmentation		
Breast Reduction		
Breast Biopsy		
Carpal Tunnel Surgery		
Cesarean Section		
Cholecystectomy (Gallbladder)		
Coronary Bypass		
D&C		
Gastric Bypass		
Hemorrhoidectomy		
Hernia Repair		
Hysterectomy		
Knee Surgery		
Lap Band		
Lasik		
Liposuction		
Lumbar Laminectomy		
Mastectomy		
Oral Surgery		
Ovarian Cystectomy		
Panniculectomy		
Pilonidal Cystectomy		
Prostate Surgery		
Tonsillectomy		
Tubal Ligation		
VBG		
Wisdom Teeth		

Any problems with anesthesia? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please describe \_\_\_\_\_

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Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

Have you ever had a hernia? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If so, what type? (Check all that apply)

\_\_\_\_\_ Umbilical                      \_\_\_\_\_ Hiatal                      \_\_\_\_\_ Inguinal (groin)                      \_\_\_\_\_

Do you currently have a hernia? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If so, what type? (Check all that apply)

\_\_\_\_\_ Umbilical                      \_\_\_\_\_ Hiatal                      \_\_\_\_\_ Inguinal (groin)                      \_\_\_\_\_

Have you had a previous blood transfusion? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, date \_\_\_\_\_ reason \_\_\_\_\_

Have you had an allergic reaction to tape? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had any food allergies? YES \_\_\_\_\_ NO \_\_\_\_\_

**Allergies to Medication**

DRUG	IF ALLERGIC (PLEASE CHECK)	INDICATE REACTION
No Know Drug Allergies		
Aspirin		
Codeine		
Demerol		
Erythromycin		
Iodine		
Keflex		
Morphine		
Penicillin		
Sulfa		
Tetracycline		

**Latex Allergy Screening Questionnaire**

Do you have an allergy to any latex products? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you experienced local swelling, itching or dermatitis associated to contact with Latex? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a history of wheel or blister formation on contact with latex products? YES \_\_\_\_\_ NO \_\_\_\_\_

Are you allergic to:

Kiwi                      YES \_\_\_\_\_ NO \_\_\_\_\_  
 Banana                      YES \_\_\_\_\_ NO \_\_\_\_\_  
 Avocado                      YES \_\_\_\_\_ NO \_\_\_\_\_  
 Chestnuts                      YES \_\_\_\_\_ NO \_\_\_\_\_

Does your occupation involve exposure to NRL? YES \_\_\_\_\_ NO \_\_\_\_\_  
 (NATURAL RUBBER LATEX)

Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

# Personal Medical Information

Have you ever been diagnosed with Cancer

YES \_\_\_\_\_ NO \_\_\_\_\_

If so, check all that apply

Breast                       Endometrial                       Prostate  
 Thyroid                       Skin                       Blood

Year Diagnosed \_\_\_\_\_

Cancer Free for \_\_\_\_\_

Treatment, check all that apply

Surgery                       Chemotherapy                       Radiation

Do you wear glasses? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you wear contacts? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have regular dental check-ups? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had previous dental surgery? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you wear dentures?

Upper? YES \_\_\_\_\_ NO \_\_\_\_\_

Lower? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have missing teeth? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, how many? \_\_\_\_\_

Have you ever had an:

EKG YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Stress Test YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Echocardiogram YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Cardiac Catheterization YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were the results

Normal                       Abnormal                       Further Testing Required

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Personal Medical History

	Have you been diagnosed with or do you suffer from each of the following? <i>Check if yes</i>	Are you currently being treated for it? <i>Check if yes</i>	Are you currently taking medication for it? <i>Check if yes</i>
<b>Head and Neck</b>			
Glaucoma			
Cataracts			
Hearing Loss			
Vertigo			
Tinnitus			
Migraine Headaches			
<b>Cardiovascular</b>			
High Blood Pressure			
Angina			
Pulmonary Hypertension			
Chest Pain with effort			
High Cholesterol			
High Blood Fats (Lipids)			
Irregular Heart Beat			
Heart Palpitations			
Congestive Heart Failure			
Leg Ulcers			
Varicose Veins			
Ankle Swelling			
<b>Respiratory</b>			
Sleep Apnea			
Shortness of Breath at Rest			
Shortness of Breath with Activity			
Emphysema			
Chronic Cough			
Wheezing			
Asthma as a child			
Asthma as an adult			
<b>Musculo-skeletal</b>			
Arthritis			
Ankle Pain			
Osteoarthritis			
Rheumatoid Arthritis			
Back Pain			
Knee Pain			
Plantar Fasciitis			
Heel Spurs			

Name: \_\_\_\_\_  
 (Please put your first and last name on each page.)

	Have you been diagnosed with or do you suffer from each of the following? <i>Check if yes</i>	Are you currently being treated for it? <i>Check if yes</i>	Are you currently taking medication? <i>Check if yes</i>
<b>Gastrointestinal</b>			
GERD			
Heartburn			
Stomach Ulcer			
Duodenal Ulcer			
Constipation			

Number of bowel movements per day \_\_\_\_\_ Number Per Week \_\_\_\_\_

Days Between bowel movements \_\_\_\_\_

Vomiting			
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\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_

If everyday, how many times per day \_\_\_\_\_

Diarrhea			
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\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_

If everyday, how many times per day \_\_\_\_\_

<b>Gallbladder Disease</b>			
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Gall Stones			
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Inflammation/Infection			
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<b>Genito-urinary</b>			
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Urinary Frequency (over 6 x per day)			
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Urinary Retention			
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Recurrent Urinary Tract Infection			
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Kidney Stones			
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Kidney Disease			
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Renal Failure			
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Gout			
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Stress Incontinence (leakage of urine)			
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\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Most Weeks      \_\_\_\_\_

If everyday, how many times per day \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

	Have you been diagnosed with or do you suffer from each of the following? <i>Check if yes</i>	Are you currently being treated for it? <i>Check if yes</i>	Are you currently taking medication? <i>Check if yes</i>
<b>OB/GYN</b>			
Irregular periods			
Excessively Heavy Periods			
Excessively Painful Periods			
Difficulty in Conceiving			
Infertility - with or without treatment			
Excess Body Hair or Acne			
<b>Endocrinology</b>			
Diabetes			
Hypothyroid			
Hyperthyroid			
Goiter			
Graves Disease			
<b>Neurological</b>			
Numbness/Tingling-hands			
-- Feet			
-- Front or side of thigh			
Seizures			
Weakness - Hands			
Weakness - Feet			
Epilepsy			
Pseudotumor Cerebri			
<b>Skin</b>			
Dermatitis			
Urticaria			
Rashes			
Open Sores			
<b>Hematology</b>			
Anemia			
Heparin Exposure			
	When? _____	Why? _____	
Coumidin Use			
	When? _____	Why? _____	
Iron Supplements			
	When? _____	Why? _____	

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

	Have you been diagnosed with or do you suffer from each of the following? <i>Check if yes</i>	Are you currently being treated for it? <i>Check if yes</i>	Are you currently taking medication? <i>Check if yes</i>
<b>Psychological</b>			
Depression			
Bi-Polar Disorder			
Anxiety			
Schizophrenia			
Anorexia			
Bulimia			
Suicide Attempt			
<b>Infectious Diseases</b>			
HIV Positive			
Staph Infection			
Liver Disease			
Hepatitis A			
Hepatitis B			
Hepatitis C			

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**DIABETES** - If you have been diagnosed with or treated for diabetes. please complete the following section

Juvenile Onset                    YES \_\_\_\_\_ NO \_\_\_\_\_    Year Diagnosed \_\_\_\_\_

Adult Onset                        YES \_\_\_\_\_ NO \_\_\_\_\_    Year Diagnosed \_\_\_\_\_

Current form of Control:

Diet Control Only                YES \_\_\_\_\_ NO \_\_\_\_\_    As of (year) \_\_\_\_\_

Oral Hypoglycemics              YES \_\_\_\_\_ NO \_\_\_\_\_    As of (year) \_\_\_\_\_

Insulin                              YES \_\_\_\_\_ NO \_\_\_\_\_    As of (year) \_\_\_\_\_

Number of injections per day \_\_\_\_\_

Do you have glycosylated hemoglobin (HBA1C) levels tested                    YES \_\_\_\_\_                    NO \_\_\_\_\_

If yes, what is your level (if you know) \_\_\_\_\_

**SLEEP APNEA** - Please complete the following even if you have not been diagnosed with sleep apnea

Do you use C-Pap?                YES \_\_\_\_\_ NO \_\_\_\_\_

Do you use Bi-Pap?                YES \_\_\_\_\_ NO \_\_\_\_\_

Please mark, which symptoms apply

- |                                                            |           |          |
|------------------------------------------------------------|-----------|----------|
| Snorting or gasping                                        | YES _____ | NO _____ |
| Loud snoring                                               | YES _____ | NO _____ |
| Breathing stops, choke or struggle for breath              | YES _____ | NO _____ |
| Frequent awakenings                                        | YES _____ | NO _____ |
| Tossing, turning or thrashing                              | YES _____ | NO _____ |
| Difficulty falling asleep                                  | YES _____ | NO _____ |
| Morning headaches                                          | YES _____ | NO _____ |
| Night sweats                                               | YES _____ | NO _____ |
| More than three pillows used under head                    | YES _____ | NO _____ |
| Falling asleep when at work or school                      | YES _____ | NO _____ |
| Falling asleep when driving                                | YES _____ | NO _____ |
| Excessive sleepiness during the day                        | YES _____ | NO _____ |
| Awaken feeling paralyzed, unable to move for short periods | YES _____ | NO _____ |

How well rested do you feel after a full nights sleep?

\_\_\_\_\_ Not at all                    \_\_\_\_\_ Somewhat                    \_\_\_\_\_ Well Rested

Do you feel more comfortable sleeping in an upright position?                    YES \_\_\_\_\_                    NO \_\_\_\_\_

Have you ever been diagnosed with Lupus?                    YES \_\_\_\_\_                    NO \_\_\_\_\_

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**GERD** - Please complete the following even if you have not been diagnosed with GERD

How often do you have reflux during the day?

Many Times Per Day \_\_\_\_\_ Everyday \_\_\_\_\_ Most Days \_\_\_\_\_ Most Weeks \_\_\_\_\_ Or

Do you suffer from heartburn/indigestion during the night? If so how often?

Many Times Per Night \_\_\_\_\_ Everynight \_\_\_\_\_ Most Nights \_\_\_\_\_ Most Weeks \_\_\_\_\_ Or

Does food or fluid reflux in the mouth? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you vomit with reflux? YES \_\_\_\_\_ NO \_\_\_\_\_

Treatments you may use for reflux, heartburn or indigestion, either prescribed or over the counter

Check all those that apply

\_\_\_\_\_ Zantac                      \_\_\_\_\_ Tagamed                      \_\_\_\_\_ Pepcid                      \_\_\_\_\_  
\_\_\_\_\_ Nexium                      \_\_\_\_\_ Prilosec                      \_\_\_\_\_ Surgery

Please list any current medical conditions or concerns not covered above.

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Details of any other hospitalizations for medical problems.

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Name: \_\_\_\_\_  
(Please put your first and last name on each page.)



## Social Profile

### Family Structure

Do you have any children ? YES \_\_\_\_\_ NO \_\_\_\_\_

How many children/grandchildren in each of the following age groups do you have living with you:

Include nieces, nephews or other dependants

\_\_\_\_\_ 0-2 years old

\_\_\_\_\_ 8-12 years old

\_\_\_\_\_ 18-25 years old

\_\_\_\_\_ 2-8 years old

\_\_\_\_\_ 12-18 years old

\_\_\_\_\_ over 25 years old

Do you have a support person friend? YES \_\_\_\_\_ NO \_\_\_\_\_

Do they live with you? YES \_\_\_\_\_ NO \_\_\_\_\_

### Combined Household Income

\_\_\_\_\_ Less than \$20,000

\_\_\_\_\_ \$40,000-\$59,999

\_\_\_\_\_ \$80,000-\$99,999

\_\_\_\_\_ \$20,000-\$39,999

\_\_\_\_\_ \$60,000-\$79,999

\_\_\_\_\_ \$100,000 or more

## Current Employment

Occupation \_\_\_\_\_

Are you currently employed? YES \_\_\_\_\_ NO \_\_\_\_\_

Employer \_\_\_\_\_

### Approximate Income

\_\_\_\_\_ Less than \$20,000

\_\_\_\_\_ \$40,000-\$59,999

\_\_\_\_\_ \$80,000-\$99,999

\_\_\_\_\_ \$20,000-\$39,999

\_\_\_\_\_ \$60,000-\$79,999

\_\_\_\_\_ \$100,000 or more

If employed, please state what level of activity your job involves:

\_\_\_\_\_ Little (sedentary job)

\_\_\_\_\_ Moderately active

Do you enjoy your work? YES \_\_\_\_\_ NO \_\_\_\_\_

If you are unemployed, How long?

What is the reason? (Check One)

\_\_\_\_\_ Physically unable to work

\_\_\_\_\_ Emotionally unable to work

\_\_\_\_\_ Lack of available jobs in the field

\_\_\_\_\_ Appearance inappropriate for position sought

\_\_\_\_\_ Lack of skills

\_\_\_\_\_ Other - Please explain \_\_\_\_\_

Are you currently disabled or on disability? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, How long? \_\_\_\_\_

### Education

\_\_\_\_\_ 8th grade or less

\_\_\_\_\_ High school graduate

\_\_\_\_\_ College graduate

\_\_\_\_\_ some high school

\_\_\_\_\_ Some college

\_\_\_\_\_ Any post graduate work

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Social Data

Do you drink coffee? YES \_\_\_\_\_ NO \_\_\_\_\_ How many cups per day \_\_\_\_\_

Do you smoke cigarettes? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes. How many per day \_\_\_\_\_  
How Long \_\_\_\_\_

Do you smoke cigars? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes. How many per day \_\_\_\_\_  
How Long \_\_\_\_\_

How long ago did you stop smoking? \_\_\_\_\_ Years \_\_\_\_\_ Months

Do you drink alcohol? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, how often?  
\_\_\_\_\_ Everyday \_\_\_\_\_ Most Days \_\_\_\_\_ Most Weeks \_\_\_\_\_ Most Month

If yes, when drinking do you tend to binge to excess? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a history of drug or alcohol addiction? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, how long have you been alcohol or drug free \_\_\_\_\_ Months

What treatment did you receive, check all that apply  
\_\_\_\_\_ Residential treatment \_\_\_\_\_ Counseling \_\_\_\_\_ Support groups such as AA

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

## Family Medical History

FATHER:

Please check one:  Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

MOTHER:

Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

SIBLING

Brother  Sister

Please check one:  Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

SIBLING  Brother  Sister  
 Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

SIBLING  Brother  Sister  
 Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

SIBLING  Living  Deceased | If Deceased: Age

Cause of death:  Cancer  Accident  Age related  Diabetes  
 Heart Disease/Stroke/Heart Attack  Other

History of Obesity YES  NO   
Heart Disease YES  NO   
Hypertension YES  NO   
Diabetes YES  NO   
History of Cancer YES  NO

If yes, check type:  Breast  Endometrial  Prostate  Colon  
 Thyroid  Skin  Blood  Other

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

SPOUSE:

History of Obesity                    YES \_\_\_\_\_ NO \_\_\_\_\_ Not Applicable \_\_\_\_\_

CHILDREN:

History of Obesity                    YES \_\_\_\_\_ NO \_\_\_\_\_ Not Applicable \_\_\_\_\_

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I ATTENDED INFO SESSION ON \_\_\_\_\_

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

**neral  
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our Choice.**

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Name: \_\_\_\_\_  
(Please put your first and last name on each page.)

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Name: \_\_\_\_\_  
(Please put your first and last name on each page.)



Pregnancy  
Middle Age

years

Name: \_\_\_\_\_  
(Please put your first and last name on each page.)



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Name: \_\_\_\_\_  
(Please put your first and last name on each page.)



Colon  
Other

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