

## WEIGHT MANAGEMENT HISTORY

This form helps us determine if you are a candidate for bariatric surgery. Please take the time to fill it out as accurately and thoroughly as possible. Authorization of your surgery will depend on you meeting the criteria set forth by your insurance company and our ability to document your medical and dietary history.

### How long have you been morbidly obese?

How many years have you been obese?	What was your highest weight?
What have been your lowest and highest weights <b>during the last five years?</b>	

### Medically supervised weight loss programs:

Weight Loss Programs		Date	Length of Program	Treating Physician	Weight Loss	Weight Regain	Estimated cost:
doctor supervised Very Low Calorie Diet	<input type="checkbox"/> Optifast <input type="checkbox"/> Medifast						
Diabetes Education							
6 month weight management program	<input type="checkbox"/> Specialist <input type="checkbox"/> Primary Care						

Sympathomimetic Medications		Date	Length of Program	Treating Physician	Weight Loss	Weight Regain	Estimated cost:
phentermine	Adipex/Suprenze						
phentermine/ fenfluramine	Phen-Fen						
phentermine/ topiramate	Qsymia						
fenfluramine	Pondimin						
diethylpropion	Tenuate						
benzphetamine	Didrex						
sibutramine	Meridia						
phendimetrazine	Bontril						
dexfenfluramine	Redux						

Non-Sympathomimetic Medications		Date	Length of Program	Treating Physician	Weight Loss	Weight Regain	Estimated cost:
topiramate	Topomax						
bupropion	Wellbutrin						
lorcaserin	Belviq						
metformin	Glucophage						
orlistat	Xenical, Alli						

## Weight Management History

**Commercial programs attended for at least 6 months:**

Calorie Reduction Strategies	Date	Length of Program	Location	Weight loss	Weight Regain	Estimated cost:
<input type="checkbox"/> Weight Watchers <input type="checkbox"/> Mediterranean <input type="checkbox"/> Mayo Clinic <input type="checkbox"/> Richard Simmons	<input type="checkbox"/> Zone <input type="checkbox"/> Pritikin <input type="checkbox"/> Ornish					
<b>Low Carb/ Low Sugar Strategies</b>						
<input type="checkbox"/> South Beach <input type="checkbox"/> Sugar Busters <input type="checkbox"/> Glucose Revolution	<input type="checkbox"/> Atkins <input type="checkbox"/> LEARN <input type="checkbox"/> DASH					
<b>Meal Replacement Strategies</b>						
<input type="checkbox"/> Nutrisystem <input type="checkbox"/> Jenny Craig	<input type="checkbox"/> Slim-Fast <input type="checkbox"/> Medifast <input type="checkbox"/> HMR					
<b>Quantified Self Strategies</b>						
<input type="checkbox"/> Welless FX <input type="checkbox"/> My Fitness Pal <input type="checkbox"/> Jawbone UP	<input type="checkbox"/> FuelBand <input type="checkbox"/> Fitbit <input type="checkbox"/> BodyBugg					
<b>Fad Diets</b>						
<input type="checkbox"/> cabbage soup <input type="checkbox"/> grapefruit <input type="checkbox"/> detox or cleanse	<input type="checkbox"/> raw <input type="checkbox"/> soup <input type="checkbox"/> HCG					
Overeaters Anonymous						
Over-the-counter diet pills						
My own diet						
Other:						

**Physical exercise programs and activities:**

Program	Estimated time spent	Length of program	Weight loss	Weight gain or regain	Currently performing?
Aerobics					Yes <input type="checkbox"/> No <input type="checkbox"/>
Bicycling					Yes <input type="checkbox"/> No <input type="checkbox"/>
Exercise videos					Yes <input type="checkbox"/> No <input type="checkbox"/>
Health club or gym					Yes <input type="checkbox"/> No <input type="checkbox"/>
Personal trainer					Yes <input type="checkbox"/> No <input type="checkbox"/>
Running					Yes <input type="checkbox"/> No <input type="checkbox"/>
Swimming					Yes <input type="checkbox"/> No <input type="checkbox"/>
Treadmill					Yes <input type="checkbox"/> No <input type="checkbox"/>
Walking					Yes <input type="checkbox"/> No <input type="checkbox"/>
Water aerobics					Yes <input type="checkbox"/> No <input type="checkbox"/>
Weightlifting					Yes <input type="checkbox"/> No <input type="checkbox"/>
Other:					Yes <input type="checkbox"/> No <input type="checkbox"/>

**For patients who have had previous weight loss surgery:**

Type of surgery	Treating surgeon	Date of surgery	Weight loss	Weight regain	Nutritional issues?
1.					Yes <input type="checkbox"/> No <input type="checkbox"/>
2.					Yes <input type="checkbox"/> No <input type="checkbox"/>
3.					Yes <input type="checkbox"/> No <input type="checkbox"/>

Please describe the three most important goals you have in seeking **revisional bariatric surgery**:

1.

2.

3.

