Medical and Surgical Weight Loss Clinic
Sacred Heart Hospital and Evergreen Surgical

Name: _____ Date of Birth: _____
Height: _____ Weight: _____
Primary Care Physician and location: _____
How did you hear about the Medical and Surgical Weight Loss Clinic?
_____

Diet History: List all previous diets, dates and outcomes

_____
_____
_____
_____
_____

Weight History:
Highest weight/date: _____ Lowest weight/date: _____
How many years have you been obese: _____
What do you think contributes to your weight:

□ Portion Sizes/Overeating □ Bad food choices □ Lack of Exercise
□ Emotional/Stress eating □ Heredity □ Other: _____

Personal Medical History:

_____
_____
_____
_____
_____

Any imaging/labs or other testing done recently? (where and when)

_____

Surgical History: (Procedure and date)

_____
_____
_____
_____
_____

Have you had previous surgery for weight loss? (If Yes, include type/when/where)

_____

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Medications: Include medication name and dose

_____
_____
_____
_____
_____
_____
_____
_____

Preferred Pharmacy: _____

Any known Allergies? _____

	Never	Currently (amount)	Quit (date)
Smoking History:	□	□ _____	□ _____
Smokeless tobacco:	□	□ _____	□ _____
Alcohol:	□	□ _____	□ _____
Drugs:	□	□ _____	□ _____

Any problems with anesthesia?

_____

Family History:
Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Have you discussed weight loss options with your Primary Care Physician?

_____

Anything else you would like us to know?

_____

If completing this form via our website, please return to:
Evergreen Surgical
719 W. Hamilton Ave, Suite C
Eau Claire, WI, 54701