

NAME: _____

DATE: _____

JERSEY SHORE ADVANCED SURGICAL ASSOCIATES
BARIATRICS

Active Co-Morbidities (circle all that apply)

High Blood Pressure	Diabetes	High Lipids	Heartburn
Heart Disease	Leg Swelling	Heart Attack	Heart Failure
Sleep Apnea	Asthma	Sleep Problems	Frequent Urination
Leakage of Urine	Pain in the Joints	Low Back Pain	Blood Clots
Menstrual Change	Loss of Sexual Desire	Depression/Anxiety	Skin Irritation

Weight History

At what age did you first have a weight problem? (circle one)

5-12 years old 13-19 years old 20-30 years old 31-40 years old 41-50 years old Over 50 years old

How many years have you been at your current weight? _____

What is your highest adult weight? _____

How long have you been 100 lbs above your ideal weight? _____

What is the most weight you've ever lost? _____

How long did you keep the weight off? _____

Was there an event that led to significant weight gain? (circle one)

Death of a loved one Trauma/Accident Illness Pregnancy Loss of a job

Dieting Habits (circle all that apply)

Skip Meals Snack Eat Large Portions Binge Eat Eat Out A lot

Have you ever tried to "go on a diet"? Yes No

How many dieting attempts have ever been made to lose weight? 1-5 6-10 11-25 >25

How many dieting attempts have been made to lose weight in the past 2 years? 1-5 6-10 11-25 >25

What kind of dieting program did you try (circle all that apply)?

Weight Watchers Jenny Craig Nutrisystem Other _____

Of these, which were successful? Please describe the outcome briefly.

Exercise Habits (circle one)

Sedentary Minimally Active Moderately Active Very Active

How many hours of TV do you watch per day? _____

How many hours do you spend in front of the computer per day? _____

How many times per week do you exercise? _____

What kind of exercise did you try to lose weight? _____

Of these, which were successful? Please describe the outcome briefly.
