THE SURGICAL WEIGHT LOSS CENTER OF HAWAII℠
KAPI'OLANI MEDICAL CENTER AT PALI MOMI, AIEA, HAWAII 96701
TEL (808) 561-5511 FAX (415) 561-1713
www.HawaiiWeightLoss.com

Patient Information

First name:					
Middle Name:					
Last Name:				Current Age:	
Date of birth:			Gender:	Male	Female
Marital status:			Social Security Number:		
E-mail:					
Street address:					
City:					
State:			Zip code:		
Phone (home):					
Phone (work):					
Phone (mobile):					
Patient's employment Status:	Full Time	Part Time	Disabled	Not Working	Student
Patient's occupation (indicate if student):					
If disabled, specify the year and cause:					
Patient's employer:				How long employed:	
Patient's employer's address:					
Spouse's name:				Spouse's date of birth:	
How did you hear about us (please include					

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as much detail as possible)?					
Any specific questions you need addressed?					
Circle your preferred procedure:	Roux-en-Y	Duodenal Switch	Lap-Band	Vertical Gastrectomy	Not Sure

Emergency Contact #1			
First name:		Last name:	
Relation to you:		Phone:	

Emergency Contact #2			
First name:		Last name:	
Relation to you:		Phone:	

Primary/Referring Doctor					
First name:		Last name:			
Street address:					
City:		State:		Zip code:	
Phone:		Fax:			

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Insurance Information					
Circle your payment Type (i.e. Employer, Self Pay, etc.):	Insurance Pay		Self Pay	Other:	
Subscriber Full Name:					
Relation to Patient:	Self		Other:		
Subscriber Date of Birth:					
Policy Type (i.e. HMO, PPO, etc.)	HMO	PPO	Other:		
Insurance Provider (i.e. Blue Cross/Blue Shield, etc.):					
Insurance Provider Phone:					
Policy ID:		Group ID:			
Subscriber Employer:					

Weight Loss History			
What is your height?		How much do you weigh?	
How long have you been obese (life-long or from what age)?		For how many years have you been at your	

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			current weight?	
What was your maximum weight?			What is the most weight you ever lost on a single diet?	
Unsupervised Diet Attempts				
Body for Life/Bill Phillips	Yes	No	wt loss:	
Gloria Marshall	Yes	No	wt loss:	
Health Spa	Yes	No	wt loss:	
High Protein	Yes	No	wt loss:	
Hypnosis	Yes	No	wt loss:	
Low Carbohydrate	Yes	No	wt loss:	
Low Fat	Yes	No	wt loss:	
Calorie Counting	Yes	No	wt loss:	
Pritkin	Yes	No	wt loss:	
Richard Simmons	Yes	No	wt loss:	
Scarsdale	Yes	No	wt loss:	
Stillman Diet	Yes	No	wt loss:	
Sugar Busters	Yes	No	wt loss:	
Slim Fast	Yes	No	wt loss:	
Mayo Clinic	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	

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Supervised Diet Attempts				
Nutri-Systems	Yes	No	wt loss:	
Diet Center	Yes	No	wt loss:	
Overeaters Anonymous	Yes	No	wt loss:	
Optifast	Yes	No	wt loss:	
Weight Watchers	Yes	No	wt loss:	
T.O.P.S	Yes	No	wt loss:	
Jenny Craig	Yes	No	wt loss:	
New Direction	Yes	No	wt loss:	
National Weight Loss	Yes	No	wt loss:	
HMR - Health Management Resources	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Other:	Yes	No	wt loss:	
Medications Prescribed for Weight Loss				
Acutrim	Yes	No	wt loss:	
Amphetamines	Yes	No	wt loss:	
Anorex	Yes	No	wt loss:	
Benzphetamine	Yes	No	wt loss:	
Dexatrim (Phenylpropanolamine)	Yes	No	wt loss:	
Didrex	Yes	No	wt loss:	

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Fastin	Yes	No	wt loss:	
Fen-Phen	Yes	No	wt loss:	
Ionamin/Adipex (Phentermine)	Yes	No	wt loss:	
Mazanor	Yes	No	wt loss:	
Meridia (Sibutramine)	Yes	No	wt loss:	
Obalan	Yes	No	wt loss:	
Phendiet	Yes	No	wt loss:	
Phentrol	Yes	No	wt loss:	
Plegine	Yes	No	wt loss:	
Pondimin (Fenfluramine)	Yes	No	wt loss:	
Prozac (Fluoxetine)	Yes	No	wt loss:	
Redux (Dexfenfluramine)	Yes	No	wt loss:	
Sanorex	Yes	No	wt loss:	
Tepanol	Yes	No	wt loss:	
Tenuate	Yes	No	wt loss:	
Wehless	Yes	No	wt loss:	
Xenical (Orlistat)	Yes	No	wt loss:	
Other 1:	Yes	No	wt loss:	
Other 2:	Yes	No	wt loss:	
Other 3:	Yes	No	wt loss:	
Behavioral Treatments for Weight Loss				
Hypnosis	Yes	No	wt loss:	
Hospitalization	Yes	No	wt loss:	
Psychologist Therapy	Yes	No	wt loss:	
Residential Programs	Yes	No	wt loss:	

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Other 1:	Yes	No	wt loss:	
Other 2:	Yes	No	wt loss:	
Other 3:	Yes	No	wt loss:	

Medical Condition / Co-Morbidity			
Metabolic/Nutritional			
Chronic Fatigue	Yes	No	
Gout	Yes	No	
High Cholesterol	Yes	No	
High Triglycerides	Yes	No	
Hyperlipidemia	Yes	No	
Thiamine Deficiency	Yes	No	
Other	Yes	No	
Neurological			
Headaches	Yes	No	
Pseudotumor Cerebri	Yes	No	
Other	Yes	No	
Endocrine			
Diabetes - Type 1 Uncontrolled	Yes	No	
Diabetes - Type 1 Controlled	Yes	No	
Diabetes - Type 2 Uncontrolled	Yes	No	
Diabetes - Type 2 Controlled	Yes	No	

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Hypoglycemia	Yes	No	
Hypothyroidism	Yes	No	
Hyperglycemia	Yes	No	
Hyperparathyroidism	Yes	No	
Insulin dependent	Yes	No	
Insulin Resistant	Yes	No	
Other	Yes	No	
Other	Yes	No	
Other	Yes	No	
Reticuloendothial			
Anemia B12	Yes	No	
Anemia Iron	Yes	No	
Other	Yes	No	
Respiratory			
Asthma	Yes	No	
Shortness of Breath	Yes	No	
Sleep Apnea	Yes	No	
CPAP/BIPAP	Yes	No	
Other	Yes	No	
Cardiovascular			
Chronic Venous Stasis Disease	Yes	No	
Congestive Heart Failure	Yes	No	
Coronary Artery Disease	Yes	No	
Dependent Edema/Lymphedema	Yes	No	
Leg Swelling/Edema	Yes	No	
Hypertension	Yes	No	

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Hypertrophic Cardiomyopathy	Yes	No	
Thromboembolic Complications	Yes	No	
Other	Yes	No	
Gastrointestinal			
Acute Pancreatitis	Yes	No	
Calculus of Bile Duct w/ other Cystitis	Yes	No	
Cholelithiasis	Yes	No	
Cirrhosis	Yes	No	
Fatty Liver	Yes	No	
Gall Bladder Disease/Cholecystitis	Yes	No	
GERD	Yes	No	
Other	Yes	No	
Integumentary			
Dermatitis Intertrigo	Yes	No	
Skin Infections	Yes	No	
Other	Yes	No	
Psychiatric			
Anxiety	Yes	No	
Depression	Yes	No	
Schizophrenia	Yes	No	
Other	Yes	No	
Gynecological			
Amenorrhea	Yes	No	
Anovulation	Yes	No	
Dysmenorrhea	Yes	No	

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Infertility	Yes	No	
Menorrhagia	Yes	No	
Menstrual Irregularity	Yes	No	
Polycystic Ovarian Syndrome	Yes	No	
Number of Pregnancies?			
Number of Children?			
Number of Miscarriages/Abortions?			
Other	Yes	No	
Urological			
Urinary Stress Incontinence	Yes	No	
Other	Yes	No	
Musculoskeletal			
Arthritis	Yes	No	
Ankle/Foot Pain	Yes	No	
Back Pain	Yes	No	
Carpal Tunnel Syndrome	Yes	No	
Degenerative Joint Disease - Multiple Joints	Yes	No	
Degenerative Joint Disease - Unspecified	Yes	No	
Hip Pain	Yes	No	
Knee Pain	Yes	No	
Neck Pain	Yes	No	
Pain in Multiple Joints	Yes	No	
Plantar Fasciitis	Yes	No	
Shoulder Pain	Yes	No	
Wrist Pain	Yes	No	

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Other	Yes	No	

Surgical History			
Appendectomy:	Yes	No	Date of Sx
Hysterectomy (Uterus removed - vaginal):	Yes	No	
Hysterectomy (Uterus removed - abdominal):	Yes	No	
Ovary Surgery:	Yes	No	
Cesarean Section:	Yes	No	
Back:	Yes	No	
Knee:	Yes	No	
Breast Biopsy:	Yes	No	
Previous Weight-Loss Surgery:	Yes	No	
Tonsillectomy:	Yes	No	
Hernia:	Yes	No	
Tubal Ligation:	Yes	No	

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Kidney Transplant:	Yes	No	
Liver Transplant:	Yes	No	
Pancreas Transplant:	Yes	No	
Other 1:	Yes	No	
Other 2:	Yes	No	
Other 3:	Yes	No	
Other 4:	Yes	No	

Allergies	
Please write the name of the medication or substance and the type of reaction you had.	
Name of Medication/Substance -	Reaction it Causes
(Ex. Medication - Rash, Difficulty breathing, etc.)	
1.	
2.	
3.	
4.	
5.	
6.	

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7.			
8.			
9.			
10.			
Problems with anesthesia?	Yes	No	Not Sure
If yes, please describe in the space provided.			

Medications / Supplements

Please write each medication's name, dosage, route (by mouth, inhaled, etc.), and frequency (once a day, twice a day, as needed) on a separate line. Include all medications or remedies taken, even those without prescriptions. Please remember to include vitamins, herbs, and supplements.

Name of Medication - - -	Strength	Dose	Reason for taking
(Example: Atenolol - 100 mg - 1 daily - High Blood Pressure)			
1.			
2.			
3.			
4.			
5.			

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6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Social History		
Do you smoke now?	Yes	No
If yes, how many cigarette packs per day?		
Do you use snuff or chew?	Yes	No
If yes, how frequently do you use snuff/chew?		
For how many years have/did you use tobacco?		
If you have quit, how long ago?		

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Do you consume alcohol now?	Yes	No
If yes, how many times a week?		
If yes, how many drinks each time?		
For how many years do/did you drink alcohol?		
If you have quit, how long ago?		
Is anyone concerned about the amount you drink?	Yes	No
Do you use street drugs now?	Yes	No
If yes, which drugs?		
If yes, how frequently do you use these drugs?		
If you have quit, how long ago?		
Do you drink coffee or other caffeine-containing beverages?	Yes	No
If yes, how many cups per day?		
Do you drink carbonated beverages?	Yes	No
If yes, how many cans per day?		
What hobbies do you have that are important to you?		
Could someone help care for you if you were seriously ill?		
Are there people for whom you are the primary care giver?		
Do you have children?	Yes	No
If so, how many?		
If married, are you satisfied with married life?	Yes	No
If working, are you satisfied with your present job?	Yes	No
Overall satisfaction with yourself?		
Do you have a history of abuse?	Yes	No
Please include emotional, physical, mental, substance, or other types of abuse issues		

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you've dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan.
Describe your present life stressors:
Describe the present support system you rely upon:
Describe your work and home life (family members, etc.). Do you have support at home?
What is your greatest fear regarding the surgery?

Family History			
Obesity	Yes	No	
Kidney disease	Yes	No	
Heart disease	Yes	No	
Diabetes mellitus	Yes	No	
High blood pressure	Yes	No	

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Alcoholism	Yes	No	
Liver problems	Yes	No	
Lung problems	Yes	No	
Bleeding disorder	Yes	No	
Gallstones	Yes	No	
Mental Illness	Yes	No	
Cancer	Yes	No	
Malignant hyperthermia	Yes	No	
Other	Yes	No	
Other	Yes	No	
Other	Yes	No	
Number of family deaths related to obesity?			

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