



# Weight Loss Information Form

Division of Plastic Surgery  
MetroHealth Medical Center

**\*PLEASE PRINT\***

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST NAME FIRST NAME MIDDLE

HOW TALL ARE YOU? \_\_\_\_\_

WHAT WAS YOUR HIGHEST ADULT WEIGHT? \_\_\_\_\_ WHAT YEAR? \_\_\_\_\_

WHAT HAS BEEN YOUR LOWEST ADULT WEIGHT? \_\_\_\_\_ WHAT YEAR? \_\_\_\_\_

WHAT IS YOUR CURRENT WEIGHT? \_\_\_\_\_ IS YOUR WEIGHT NOW STABLE?  YES  NO

HOW DID YOU LOOSE YOUR WEIGHT?  DIET/EXERCISE  BARIATRIC SURGERY

IF YOU HAD BARIATRIC SURGERY: WHAT SPECIFIC PROCEDURE DID YOU HAVE? \_\_\_\_\_

WHO WAS YOUR BARIATRIC SURGEON? \_\_\_\_\_

AT WHAT HOSPITAL WAS THE SURGERY PERFORMED? \_\_\_\_\_

**FOR EACH OF THE FOLLOWING MEDICAL CONDITIONS, CHECK THE BOX UNDER THE STATEMENT THAT BEST FITS YOUR MEDICAL HISTORY:**

Medical Condition	"I never had this condition"	"I had this condition but it has completely gone away with my weight loss"	"I have this condition but it has improved with my weight loss"	"I have this condition and it has NOT improved with weight loss"
Diabetes				
Gastroesophageal reflux (GERD)				
Sleep apnea				
High blood pressure				
Asthma				
Arthritis				
Urinary incontinence				
Leg swelling				
High cholesterol				

DO YOU HAVE A HERNIA THAT HAS BEEN DIAGNOSED BY A PHYSICIAN? \_\_\_\_\_

HOW MUCH PROTEIN ARE YOU EATING EACH DAY? (if known) \_\_\_\_\_

WHAT DIET SUPPLEMENTS ARE YOU TAKING (e.g. iron, B12, vitamins)? \_\_\_\_\_

DO YOU HAVE SKIN RASHES? ALWAYS \_\_\_\_\_ SOMETIMES \_\_\_\_\_ NEVER \_\_\_\_\_ AREA(S) AFFECTED? \_\_\_\_\_

IF YOU HAVE SKIN RASHES, HOW DO YOU TREAT THE AREA? \_\_\_\_\_

**THIS SPACE FOR OFFICE USE:**