

Dr Vytauras Kuzinkovas

Advanced Surgicare

Weight Loss History

General Weight Loss Questions

How long have you suffered with excess weight?	years
When were you at your heaviest?	
Approximately how heavy were you?	kgs
How long have you been seriously trying to lose weight?	years
What is the maximum weight lost by any method?	kgs

Which of the following have you tried?

<i>Dieting</i>	Yes	No
Jenny Craig	<input type="checkbox"/>	<input type="checkbox"/>
Weight Watchers	<input type="checkbox"/>	<input type="checkbox"/>
Sure Slim	<input type="checkbox"/>	<input type="checkbox"/>
Atkins	<input type="checkbox"/>	<input type="checkbox"/>
Liquid Diets	<input type="checkbox"/>	<input type="checkbox"/>
<i>Diet Pills</i>	<input type="checkbox"/>	<input type="checkbox"/>
Duramine	<input type="checkbox"/>	<input type="checkbox"/>
Xenical	<input type="checkbox"/>	<input type="checkbox"/>
Reductil	<input type="checkbox"/>	<input type="checkbox"/>
<i>Professional Advice</i>	<input type="checkbox"/>	<input type="checkbox"/>
Local Doctor	<input type="checkbox"/>	<input type="checkbox"/>
Dietitian	<input type="checkbox"/>	<input type="checkbox"/>
Naturopath	<input type="checkbox"/>	<input type="checkbox"/>
Hypnotherapist	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncturist	<input type="checkbox"/>	<input type="checkbox"/>

Previous Weight Loss Surgery

Procedure:	Date:

Exercise

Are you doing any regular exercise at the present time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what type?		
How many hours per week?		
After your surgery, would you be willing to speak to other patients who are considering surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

OFFICE USE ONLY

Height:	Weight:
BMI:	Goal Weight:
Excess Weight:	

Name: _____