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

Office Use Only
Date Received: ______________
Appt: __________
Initial: _____

Name: ____
Date of Birth: ____________ Weight: _________ Height: _________

How did you hear about the Medical and Surgical Weight Loss Clinic?
____

Have you attended a Patient Information Session? ______ Date: ____________

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: ______________

Diet History:
List all previous diets, dates, and outcome:
____
____
____
____
____

Smoking History: ○ Currently, Amount:_______ ○ Quit, Date: _______ ○ Never
Alcohol Use: ○ Currently, Amount:_______ ○ Quit, Date: _______ ○ Never
Drug Use: ○ Currently, Amount:_______ ○ Quit, Date: _______ ○ Never

Have you had previous surgery for weight loss?
○ No ○ Yes, if so which type/where/when: ________________________________

Have you discussed weight loss options with your Primary Care Physician?
○ Yes ○ No

Medical History: (eg. Diabetes, High Blood Pressure, Sleep Apnea, etc...)

Name: ___________________________ DOB: ______________________

Surgical History:

Procedure	Date

Medications:

Name	Dose

Any known allergies?

____

Any problems with anesthesia?

____

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