The Center for Weight Loss Surgery at Milford Regional

Information Session Questionnaire

FreshStart
It's not about what you lose...it's about what you gain.

INFORMATION SESSION MEETING DATE: _____

PATIENT INFORMATION

Name _____

Date of Birth _____ Age _____

Street Address _____

Town _____ State ____ Zip _____

Primary Care Provider _____

Insurance _____

PLEASE SPECIFY IF OUT-OF-STATE

PHONE NUMBERS

We will contact you during daytime office hours.

		CIRCLE ONE	
Home _____	OK to leave a message?	YES	NO
Cell _____	OK to leave a message?	YES	NO
Work _____	OK to leave a message?	YES	NO

PRESENT WEIGHT _____

BEST ESTIMATE IS OK

HEIGHT _____

MEDICAL HISTORY

	CIRCLE ONE			CIRCLE ONE	
High Blood Pressure	Yes	No	Are you taking medication for this problem?	Yes	No
Diabetes	Yes	No	Are you taking medication for this problem?	Yes	No
High Cholesterol	Yes	No	Are you taking medication for this problem?	Yes	No
Heart Disease	Yes	No	Are you taking medication for this problem?	Yes	No
Sleep Apnea	Yes	No	If yes, are you using treatment?	Yes	No

If you've never been tested for sleep apnea, do you have loud snoring, poor sleep or daytime sleepiness? **Yes** **No**

Have you had weight loss surgery (gastric bypass, gastric band or other) in the past? **Yes** **No**

Have you accessed the services of our weight loss surgery program before? **Yes** **No**

MEDICATION LIST

Include medication names...dosages are not required.
Continue on back if needed.

Please list any other medical issues here: _____

OFFICE USE:

N.P. APPT: _____

The Center for Weight Loss Surgery at Milford Regional

14 Prospect Street • Milford, MA 01757 • 508-422-2474
The hearing impaired may call 508-473-5103

In partnership with: UMassMemorial Health Care

Milford Regional Medical Center