Describe your personal goal for joining a weight loss management program: ________________________________

# of Years Overweight: ________ years  Desired Weight: _______ lbs
Would like to be at desired weight by: ________________
Maximum Lifetime Weight (non-pregnant): ________ lbs  Date: ____________
Have you ever tried dieting to lose weight?  ___No  ___Yes
   If yes, please check which diets:
   [ ] Atkins  [ ] Mediterranean
   [ ] Jenny Craig  [ ] Nutri-System
   [ ] Keto  [ ] Slim 4 Life
   [ ] Medifast/Optifast  [ ] Weight Watchers
   [ ] Other: ________________________________
Have you ever tried using medication to lose weight?  ___No  ___Yes
   If yes, please check which medications taken:
   [ ] Acutrim  [ ] Dexfenfluramine
   [ ] Adipex-P  [ ] Didrex
   [ ] Amphetamines  [ ] Fastin
   [ ] Anorex  [ ] Fen-Phen
   [ ] Benzphetamine  [ ] Phentermine
   [ ] Dezatrim  [ ] Xenical
   [ ] Other: ________________________________
Have you ever had weightloss surgery?  ___No  ___Yes
   If yes, which surgery? ___________________________  Date: ____________

SLEEP HABITS
Do you have difficulty sleeping?  ___No  ___Yes
   If yes, describe:____________________________________________________________

Do you snore?  ___No  ___Yes  Has anyone ever told you that you snore?  ___No  ___Yes

Have you ever been told you have obstructive sleep apnea?  ___No  ___Yes
Have you ever had a sleep study done?  ___No  ___Yes
   If yes:  Date: ____________  Doctor: _______________________

Do you have a CPAP/BIPAP (circle one) machine?  ___No  ___Yes
   If yes:  Setting: ____________ CWP
Do you use your CPAP/BIPAP machine every night?  ___No  ___Yes
   If no, reason:____________________________________________________________

History of apparent airway obstruction during sleep
   Check the following that apply:
   [ ] Snoring (loud enough to be heard through a closed door)
   [ ] Awakens from sleep with choking sensation
   [ ] Observed pauses in breathing during sleep
   [ ] Frequent snoring
   [ ] Frequent arousals from sleep
   [ ] Talking in your sleep

History of somnolence
   Check the following that apply:
   [ ] Somnolence or fatigue, despite adequate sleep
   [ ] Falls asleep easily in a nonstimulating environment despite adequate sleep
   [ ] Difficult to arouse at usual awakening time
### PSYCHO-SOCIAL

Please describe your relationship with each of the following:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/ Significant Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child(ren)</td>
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<tr>
<td>Other Family</td>
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<td></td>
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<tr>
<td>Finances</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

What do you do to handle stress? _______________________________________________________

Do you have a history of physical, sexual, or emotional abuse? ___No ___Yes
   If yes, describe: ________________________________________________________________

Have you ever attempted suicide? ___No ___Yes

Have you ever received treatment for psychiatric illness (ex. Depression)? ___No ___Yes
   If yes, type of illness: _________________________________________________________

### ANESTHESIA HISTORY

Has any family member had a problem with anesthesia? ___No ___Yes
   If yes, describe: ______________________________________________________________

Have you had a problem with anesthesia? ___No ___Yes
   If yes, describe: ______________________________________________________________

Do you have difficulty moving your head side-to-side? ___No ___Yes

Do you have difficulty opening or closing your jaw? ___No ___Yes