



HEALTH HISTORY QUESTIONNAIRE
Puget Sound Surgical Center
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Please complete and return this form to PSSC by March 5.

Fill & Fluoro Medical History

Provide the following information on your lap band surgery:

Date of surgery: _____
Place of surgery: _____
Type of band: _____
Date of last fill and fluoro (if applicable): _____

Patient Name: _____
Address: _____

Day time telephone: _____ Evening telephone: _____
Primary Care Physician: _____ Referring Physician: _____
Address: _____ Phone number: _____

Phone number: _____ E-mail: _____

Weight History:
Age: _____ Height: _____ Current Weight: _____ BMI: _____

Approximate Weight:
20 years ago: _____ 10 years ago: _____ 5 years ago: _____ 2 years ago: _____
1 year ago: _____ 6 months ago: _____

What age did you become obese? _____ IBW _____
What was your lowest adult weight? _____ % IBW _____
What was your highest adult weight? _____ Goal _____
What is your desired or goal weight? _____

Please describe your age and situation (major stress, if any) at the onset of your obesity:

WEIGHT LOSS PROGRAMS/DIETS/MEDICATIONS

Maximum weight loss on any program: _____
Maximum length of time you kept the weight off: _____

Questions? Call 425-778-2220.

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