Ali Totonchi, M.D.

TOTONCHI
PLASTIC SURGERY

Weight Loss Information Form

Division of Plastic Surgery
MetroHealth Medical Center

PLEASE PRINT

PATIENT NAME_____ BIRTH DATE____/____/____
LAST NAME FIRST NAME MIDDLE

HOW TALL ARE YOU? _____

WHAT WAS YOUR HIGHEST ADULT WEIGHT? _____ WHAT YEAR? _____

WHAT HAS BEEN YOUR LOWEST ADULT WEIGHT? _____ WHAT YEAR? _____

WHAT IS YOUR CURRENT WEIGHT? _____ IS YOUR WEIGHT NOW STABLE? ☐ YES ☐ NO

HOW DID YOU LOOSE YOUR WEIGHT? ☐ DIET/EXERCISE ☐ BARIATRIC SURGERY

IF YOU HAD BARIATRIC SURGERY: WHAT SPECIFIC PROCEDURE DID YOU HAVE? _____

WHO WAS YOUR BARIATRIC SURGEON? _____

AT WHAT HOSPITAL WAS THE SURGERY PERFORMED? _____

FOR EACH OF THE FOLLOWING MEDICAL CONDITIONS, CHECK THE BOX UNDER THE STATEMENT THAT BEST FITS YOUR MEDICAL HISTORY:

Medical Condition	"I never had this condition"	"I had this condition but it has completely gone away with my weight loss"	"I have this condition but it has improved with my weight loss"	"I have this condition and it has NOT improved with weight loss"
Diabetes				
Gastroesophageal reflux (GERD)				
Sleep apnea				
High blood pressure				
Asthma				
Arthritis				
Urinary incontinence				
Leg swelling				
High cholesterol				

DO YOU HAVE A HERNIA THAT HAS BEEN DIAGNOSED BY A PHYSICIAN? _____

HOW MUCH PROTEIN ARE YOU EATING EACH DAY? (if known) _____

WHAT DIET SUPPLEMENTS ARE YOU TAKING (e.g. iron, B12, vitamins)? _____

DO YOU HAVE SKIN RASHES? ALWAYS_____ SOMETIMES_____ NEVER _____ AREA(S) AFFECTED? _____

IF YOU HAVE SKIN RASHES, HOW DO YOU TREAT THE AREA? _____

THIS SPACE FOR OFFICE USE: