

**Saint Luke's Hospital
Kansas City, MO 64111**

Outpatient Multidisciplinary Medical History & Database

**White portion to be completed by
Patient/ Family**

All potential patients will be required to have an sleep study if you have not had one done in the past 5 years.
Have you had a sleep study in the past 5 years? YES NO

YES NO

- Witnessed Apnea
- Sleep Walking/Talking
- Sleepy Driving
- Snoring
- Fatigue
- Night Terrors
- Limb Movement
- Respiratory Failure
- Enuresis
- Daytime Sleepiness
- Seizures
- Fragmented Sleep
- AM Headaches

Shift Work? YES NO

Bedtime: _____ AM / PM Waketime: _____ AM / PM

Weigh Loss History

How long have you been overweight? _____

What kind of exercise program have you tried? _____

Do you do any type of physical activity? YES NO

If yes please list below:

Activity e.g. swimming, jogging, walking, etc	Frequency e.g. daily, weekly, monthly, etc

Is there anything we need to know about your religion, culture, or background to give you better care?

**Gray portion to be completed by
Healthcare Provider**

YES NO

 Sleep Study ordered
 Copy of previous sleep study requested. Date _____

Plan of Care initiated by Exercise Physiologist

One consultation visit

Three months

Six months

Learning preferences Discussion Video Reading
 Demonstration No preference

Primary Language English Spanish Other _____

Factors affecting patient teaching ,care, and diet

____ Cultural ____ Religious ____ Physical
____ Hearing ____ Cognitive ____ Visual
____ Emotional ____ Readiness/motivation

Can't/doesn't read, explain _____

List learning needs identified by patient/family _____

No factors affecting learning needs identified

Pre-procedure education provided

Patient Label:

Diet History

Please identify the diet program(s) listed below that you have tried. Many insurance companies require documented evidence of more than 4 previous weight loss attempts so it is critical that you fill this portion out in detail.

Self Directed Programs Please circle all that apply


6-week Body Makeover Plan	Exercise	Low calorie	Slim Fast
Accutrim	Fastin	Low carbohydrate	Slim4Life
Acupuncture (ear stapling)	Fen-Phen	Low cholesterol/low fat	South Beach Diet
Adipex	Grapefruit Diet	Medifast / Optifast	Stacker II
Alli	HerbaLife	Meridia	Sugar Busters
Atkins	Hoodia	Metabolife	T.O.P.S.
Behavior Modification	Hypnosis	Michael Thurmond's "Biggest Loser Diet"	Trim Spa
Body-4-Life	Nutritionist	Nutrisystem	Weigh Down Program
Cardiac Rehab Program	Jenny-Craig	Phen-phen	Xenadrine
Curves	Inches Away program	Pondimin	Xenical
Dexitrim	Injections	Psychiatrist/therapy	The "Zone" diet
Diabetic Diet	Jaws wired	Relacore	
ediet.com	L.A. Weight Loss	Richard Simmons programs	
Supervised Programs			
Diet pills from MD	Physician Wt Loss	Nutri-System	
Supervised calorie counting diet by RD	Overeaters Anonymous	Weight Watchers	
Other			

Plan of care initiated by Registered Dietician

One consultation visit

Three months

Six months

 Signature of healthcare provider completing/reviewing assessment and initiating consults

Patient Label:

ALLERGIES (MEDICATIONS/ ANESTHESIA/ DYES/ TAPE/ IODINE/ LATEX* / BETADINE/ FOOD/ OTHER)			
Item	Type of reaction	Item	Type of reaction

Latex precautions initiated

CURRENT MEDICATIONS



(list all prescriptions and over the counter medications, i.e. vitamins, diet aids, herbs, laxatives, inhalers)

NONE

Current Medication	Dose	Schedule	Last Taken	Current Medication	Dose	Schedule	Last Taken

MEDICAL CONDITIONS CURRENTLY BEING TREATED FOR

Condition	Physician

<input type="checkbox"/> The above is an accurate list of Medical History
 Patient signature: _____
Signature of healthcare provider completing/reviewing assessment and initiating consult
 Signature: _____

Patient Label: