Main Line Health Bariatric Center

HEALTH INFORMATION PACKET

Thank you for choosing the Main Line Health Bariatric Center based at Bryn Mawr Hospital.

In order to maximize your first visit to our office, it would be helpful if you could complete this health information packet ahead of time. You may bring it with you to the appointment, or for your convenience, we have listed our mailing address, fax number and email address if you would like to return it before your appointment. If you require assistance in completing the health packet in its entirety or have questions, please let us know. Our team will be happy to help you.

Thank you!

phone **484.476.6230**
fax **484.592.0132**
email **bariatrics@mlhs.org**
address **830 Old Lancaster Road | Suite 300 | Bryn Mawr, PA 19010**

Preoperative Patient Health Data

DEMOGRAPHICS:

PATIENT NAME: ______________________________ DATE OF BIRTH: ___________ AGE: _______ SEX: ☐ MALE ☐ FEMALE

ADDRESS: ____

CITY: ____ STATE: ________ ZIP: _____________

EMAIL: ____

PRIMARY PHONE: ______________________ CELL PHONE: ______________________ WORK PHONE: __________________

May we leave a message at either of these phone numbers? ☐ Yes ☐ No

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ PARTNERED

EMPLOYED: ☐ YES ☐ NO IF SO, OCCUPATION: ______________________________________

EMPLOYER: ____

How did you hear about us?

☐ *Billboard* ☐ *Brochure* ☐ *Health Fair* ☐ *Health Plan* ☐ *Internet* ☐ *Jeff Now* ☐ *Mass Mailing* ☐ *Newspaper* ☐ *Ongoing Care*

☐ *Other* ☐ *Patient* ☐ *Phys Offer/ER* ☐ *Relative* ☐ *Radio* ☐ *TV* ☐ *Word of Mouth*

PHARMACY NAME ______________________ **PHONE #:** _________________ **PREFERRED LAB:** ______________________

PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME: ____

PHONE: _________________________ FAX: _________________________

PRIMARY PHYSICIAN NAME: ___________________________

PHONE: _________________________ FAX: _________________________

SPECIALTY: _________________________ PHYSICIAN NAME: ______________________________

PHONE: _________________________ FAX: _________________________

SPECIALTY: _________________________ PHYSICIAN NAME: ______________________________

PHONE: _________________________ FAX: _________________________

PAST MEDICAL HISTORY

(PLEASE CHECK THE BOX NEXT TO YOUR MEDICAL CONDITION)

☐ ANGINA
☐ BLEEDING PROBLEMS
☐ BLOOD CLOTS
☐ CANCER
a. TYPE: _______________
☐ HEART ATTACK
☐ HEART VALVE DISORDER
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ HIGH TRIGLYCERIDES
☐ LEG SWELLING/ULCERS
☐ STROKE
☐ ARTHRITIS
☐ BACK PAIN
☐ JOINT PAIN
☐ PLANTAR FASCIITIS
☐ DIABETES

☐ GESTATIONAL DIABETES
☐ LOW TESTOSTERONE
☐ MALE PATTERN HAIR GROWTH (WOMEN)
☐ METABOLIC SYNDROME
☐ PREDIABETES
☐ THYROID DISEASE
☐ CELLIAC DISEASE
☐ CROHN'S DISEASE
☐ DIVERTICULOSIS
☐ FATTY LIVER DISEASE
☐ GALLSTONES
☐ GASTRIC ULCERS
☐ HEARTBURN/GERD
☐ HEPATITIS
☐ IRRITABLE BOWEL SYNDROME

☐ PANCREATITIS
☐ ASTHMA
☐ COPD
☐ LUNG DISEASE
☐ PICKWICKIAN SYNDROME
☐ SNORING
☐ SLEEP APNEA
☐ DECREASED LIBIDO
☐ ENDOMETRIOSIS
☐ INFERTILITY
☐ IRREGULAR MENSES
☐ MENOPAUSAL
☐ POLYCYSTIC OVARY SYNDROME
☐ RECURRENT UTI
☐ RECURRENT YEAST INFECTION

☐ URINARY INCONTINENCE
☐ ADHD
☐ DEPRESSION
☐ EATING DISORDER
☐ GOUT
☐ KIDNEY DISEASE
☐ KIDNEY STONES
☐ LOW BLOOD SALT
☐ LOW BLOOD POTASSIUM
☐ HEADACHES/MIGRAINE
☐ SEIZURES
☐ PSEUDOTUMOR CEREBRI
☐ DISCOLORED SKIN PATCHES
☐ SKIN RASHES
☐ SKIN TAGS
☐ MAJOR INFECTIOUS DISEASE
☐ **OTHER**

Preoperative Patient Health Data

ALLERGIES

PLEASE LIST ALL MEDICATIONS, FOODS, SUBSTANCES YOU ARE ALLERGIC TO AND INDICATE WHAT HAPPENS WHEN YOU ARE EXPOSED TO IT (EXAMPLE: PENICILLIN > RASH)

PRESCRIPTIONS

ALL PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS/MINERALS (E.G., CALCIUM, ONE-A-DAY), HERBALS (E.G., ST. JOHN'S WORT), TYLENOL, ADVIL, EX-LAX

PRESCRIPTION NAME	DOSE (E.G., "MG")	TIMES PER DAY YOU TAKE	WHY YOU TAKE

PRIOR SURGERIES, PROCEDURES, AND PREGNANCIES

(PLEASE LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD)

DATE	SURGERY / PROCEDURES / PREGNANCIES	DATE	SURGERY / PROCEDURES / PREGNANCIES

Preoperative Patient Health Data

FAMILY MEDICAL HISTORY

☐ CHECK IF ADOPTED

	AGE	MEDICALCONDITIONS	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLING			
SIBLING			
SIBLING			

FAMILY WEIGHT HISTORY

MOTHER	FATHER	SIBLINGS
☐ NORMAL WEIGHT ☐ SLIGHTLY OVERWEIGHT (-30 POUNDS) ☐ MODERATELYOVERWEIGHT ☐ MARKEDLY OVERWEIGHT (+100 POUNDS)	☐ NORMAL WEIGHT ☐ SLIGHTLY OVERWEIGHT (-30 POUNDS) ☐ MODERATELYOVERWEIGHT ☐ MARKEDLY OVERWEIGHT (+100 POUNDS)	☐ NORMAL WEIGHT ☐ SLIGHTLY OVERWEIGHT (-30 POUNDS) ☐ MODERATELYOVERWEIGHT ☐ MARKEDLY OVERWEIGHT (+100 POUNDS)
CHILDREN	**SPOUSE**	
☐ NORMAL WEIGHT ☐ SLIGHTLY OVERWEIGHT (-30 POUNDS) ☐ MODERATELYOVERWEIGHT ☐ MARKEDLY OVERWEIGHT (+100 POUNDS)	☐ NORMAL WEIGHT ☐ SLIGHTLY OVERWEIGHT (-30 POUNDS) ☐ MODERATELYOVERWEIGHT ☐ MARKEDLY OVERWEIGHT (+100 POUNDS)	

SOCIAL HISTORY

PLEASE CHECK THE BOX THAT BEST APPLIES TO YOU

TOBACCO USE			
☐ CURRENT EVERY DAY SMOKER	☐ CURRENT SOME DAY SMOKER	☐ FORMER SMOKER	☐ NON-SMOKER
HOW MANY PACKS PER DAY?	HOW MANY YEARS HAVE YOU BEEN SMOKING?		QUIT DATE:
SMOKELESS TOBACCO USE			
☐ CURRENT USER	☐ FORMER USER	QUIT DATE:	☐ NEVER USED
ALCOHOL USE			
HOW MANY SERVINGS OF ALCOHOL DO YOU USUALLY HAVE PER WEEK?		☐ 0 ☐ 1 - 2 ☐3 - 4 ☐5 – 7 ☐8+	
☐ BEER	☐ LIQUOR	☐ WINE	☐ STANDARD DRINK OR EQUIVALENT
ILLICIT DRUGS USE			
DO YOU HAVE A HISTORY OF ILLICIT DRUG USE?	☐ YES ☐ NO		
SEXUALLY ACTIVITY			
HAVE YOU BEEN SEXUALLY ACTIVE IN THE PAST 12 MONTHS?		☐ MEN ☐ WOMEN ☐BOTH	

Name________________________

Preoperative Patient Health Data

PERSONAL WEIGHT LOSS HISTORY

CURRENT WEIGHT	LENGTH OF TIME AT CURRENT WEIGHT	
LOWEST WEIGHT	HIGHEST WEIGHT	WEIGHT AT 18 YEARS OLD
HEIGHT	GOAL (DESIRED) WEIGHT	
GREATEST WEIGHT LOSS	HOW	WHEN

WEIGHT LOSS METHODS ATTEMPTED	WEIGHT LOSS	SUPERVISED BY PHYSICIAN	SUSTAINED OVER SIX MONTHS	ATTEMPTED WITHIN THE LAST TWO YEARS
☐ NONE				
COMMERCIAL PROGRAMS				
☐ WEIGHT WATCHERS		☐	☐	☐
☐ JENNY CRAIG		☐	☐	☐
☐ OPTIFAST		☐	☐	☐
☐ NUTRISYSTEM		☐	☐	☐
☐ ATKINS		☐	☐	☐
☐ TOPS		☐	☐	☐
☐ OA		☐	☐	☐
☐ SOUTH BEACH DIET		☐	☐	☐
☐ RICHARD SIMMONS		☐	☐	☐
☐ HERBALIFE		☐	☐	☐
☐ PRITIKIN		☐	☐	☐
MEDICATIONS				
☐ FEN-PHEN		☐	☐	☐
☐ MERIDIA		☐	☐	☐
☐ XENICAL		☐	☐	☐
☐ AMPETAMINES		☐	☐	☐
☐ PHENTERMINE		☐	☐	☐
☐ ACUTRIM		☐	☐	☐
☐ TOPAMAX		☐	☐	☐
☐ DEXATRIM		☐	☐	☐
☐ REDUX		☐	☐	☐
☐ MEDIFAST		☐	☐	☐
☐ LAXATIVES		☐	☐	☐
BEHAVIOR MODIFICATION				
☐ PSYCHOTHERAPY		☐	☐	☐
☐ HYPNOSIS		☐	☐	☐
☐ ACUPUNCTURE		☐	☐	☐
☐ CONSULT WITH REGISTERED DIETITIAN		☐	☐	☐
OTHER				
☐ HEALTH CLUB MEMBERSHIP		☐	☐	☐

Name______________________

Preoperative Patient Health Data

FOOD INTAKE

DO YOU EAT BREAKFAST EVERY DAY? ☐ YES ☐ NO			
HOW MANY MEALS DO YOU EAT PER DAY?			
HOW MANY SNACKS DO YOU EAT PER DAY?			
WHAT FOODS DO YOU EAT ON A TYPICAL DAY?			
HOW MANY SERVINGS OF FLUIDS DO YOU CONSUME PER DAY?			
WATER		COFFEE/TEA	
NON-FAT OR REDUCED FAT MILK		WHOLE MILK	
DIET SODA		REGULAR SODA	
FRUIT JUICE		SPORTS DRINK	
ALCOHOLIC BEVERAGES			
DO YOU HAVE ANY INTOLERANCE? ☐ YES ☐ NO			
DO YOU HAVE ANY SPECIAL DIET? ☐ YES ☐ NO			
HOW FAST DO YOU NORMALLY EAT? (CIRCLE ONE)	SLOWLY	MODERATELY	QUICKLY

PHYSICAL ACTIVITY:

DOES BACK/JOINT PAIN INTERFERE WITH SLEEP? ☐ YES ☐ NO
ARE YOU ABLE TO EXERCISE? ☐ YES ☐ NO IF YES, HOW OFTEN?
DESCRIBE YOUR LIMITATIONS TO EXERCISE:
DESCRIBE EXERCISE YOU DO AND YOUR TOLERANCE TO IT:

Name_______________________

Preoperative Patient Health Data

PLEASE PLACE ✓ IN THE APPROPRIATE BOX

REVIEW OF SYMPTOMS

CARDIOVASCULAR DISEASE

HYPERTENSION (HIGH BLOOD PRESSURE)

☐ 0) NONE
☐ 1) BORDERLINE HIGH, NO MEDICATIONS
☐ 2) DIAGNOSIS OF HYPERTENSION, NO MEDS
☐ 3) USE SINGLE MED
☐ 4) USE MORE THAN ONE MED
☐ 5) POORLY CONTROLLED BY MEDS, ORGAN DAMAGE

HEART FAILURE (CONGESTIVE HEART FAILURE): SHORTNESS OF BREATH, FATIGUE, EDEMA

☐ 0) NONE
☐ 1) CLASS I: SYMPTOMS WITH MORE THAN ORDINARY ACTIVITY
☐ 2) CLASS II: SYMPTOMS WITH ORDINARY ACTIVITY
☐ 3) CLASS III: SYMPTOMS WITH MINIMAL ACTIVITY
☐ 4) CLASS IV: SYMPTOMS AT REST

DO YOU HAVE AN ENLARGED HEART ON ULTRASOUND? ☐ YES ☐ NO

ISCHEMIC HEART DISEASE

☐ 0) NONE
☐ 1) ABNORMAL EKG (OCC SKIPPED BEATS OR FAST HEART BEAT OR ATRIAL FIBRILLATION)
☐ 2) HISTORY OF HEART ATTACK OR ANTI-ISCHEMIC MED
☐ 3) STENT OR CABG
☐ 4) ACTIVE CHEST PAIN

CHEST PAIN

☐ 0) NONE
☐ 1) CHEST PAIN WITH EXTREME EXERTION OR EXERCISE (RUNNING, SWIMMING, ETC.)
☐ 2) CHEST PAIN WITH MODERATE EXERTION OR EXERCISE
☐ 3) CHEST PAIN WITH MINIMAL EXERTION OR AT REST (WALKING ACROSS ROOM)
☐ 4) CHEST PAIN AT REST

DO YOU HAVE PACEMAKER? ☐ YES ☐ NO

PERIPHERAL VASCULAR DISEASE

☐ 0) NONE
☐ 1) NO SYMPTOMS WITH BRUIT
☐ 2) LEG PAIN WITH WALKING, ON CIRCULATION MED
☐ 3) MINI-STROKE OR LEG PAIN WITH WALKING, RELIEVED BY REST
☐ 4) PROCEDURE FOR PERIPHERAL VASCULAR DISEASE (STENT, ANGIOPLASTY)
☐ 5) STROKE, LOWER EXTREMITY TISSUE LOSS

LOWER EXTREMITY EDEMA

☐ 0) NONE
☐ 1) INTERMITTENT LOWER EXTREMITY EDEMA, NO TREATMENT
☐ 2) LEG EDEMA REQUIRING MED, ELEVATION, DIURETICS, STOCKINGS
☐ 3) STASIS ULCERS
☐ 4) DISABILITY, INFECTIONS, CANNOT WALK

DVT/PE

☐ 0) NONE
☐ 1) HISTORY OF DVT RESOLVED WITH ANTI-COAGULATION
☐ 2) RECURRENT DVT, LONG TERM ANTI-COAGULATION MEDS
☐ 3) PREVIOUS PE
☐ 4) RECURRENT PE DECREASED FUNCTION
☐ 5) VENA CAVAL FILTER

DO YOU:

☐ HAVE SUPERFICIAL PHLEBITIS
☐ TAKE BIRTH CONTROL PILLS
☐ TAKE BLOOD-THINNING MEDICATIONS (ANTICOAGULANTS)
☐ HAVE LUPUS
☐ HAVE FACTOR V LEIDEN DISORDER
☐ HAVE AN ABNORMALITY IN PROTEIN C OR PROTEINS HAVE

YOU HAD MULTIPLE MISCARRIAGES? ☐ YES ☐ NO

METABOLIC DISEASE

GLUCOSE DISORDER

☐ 0) NONE
☐ 1) ELEVATED FASTING BLOOD SUGAR
☐ 2) DIABETES CONTROLLED WITH ORAL MEDS
☐ 3) DIABETES CONTROLLED WITH INSULIN
☐ 4) DIABETES CONTROLLED WITH ORAL MEDS AND INSULIN
☐ 5) DIABETES WITH EYE, KIDNEY, NERVOUS OR CIRCULATION PROBLEMS

LIPID DISORDER

☐ 0) NONE
☐ 1) PRESENT BUT NO TREATMENT
☐ 2) CONTROLLED WITH DIET MODIFICATION
☐ 3) CONTROLLED WITH SINGLE MED
☐ 4) CONTROLLED WITH MULTIPLE MEDS
5) POORLY CONTROLLED

GOUT DISORDER

☐ 0) NONE
☐ 1) HIGH URIC ACID, NO SYMPTOMS
☐ 2) HIGH URIC ACID, ON MEDS
☐ 3) JOINT ABNORMALITY
☐ 4) DESTRUCTIVE JOINTS

RESPIRATORY DISEASE

OBSTRUCTIVE SLEEP APNEA

☐ 0) NONE
☐ 1) SYMPTOMS BUT NEGATIVE SLEEP STUDY OR NOT ALONE
☐ 2) DIAGNOSED WITH SLEEP STUDY, NO APPLICATION (CPAP, BIPAP)
☐ 3) OSA REQUIRING APPLIANCE (CPAP, BIPAP)
☐ 4) OSA WITH HYPOXIA OR O2 DEPENDENT
☐ 5) OSA WITH PULMONARY HYPERTENSION

☐ CPAP SETTING ______________ BIPAP SETTING ___________

OBESITY HYPOVENTILATION SYNDROME

☐ 0) NONE
☐ 1) LOW OXYGEN OR HIGH CO2 ON ROOM AIR
☐ 2) SEVERELY LOW OXYGEN OR HIGH CO2
☐ 3) PULMONARY HYPERTENSION
☐ 4) RIGHT HEART FAILURE
☐ 5) RIGHT AND LEFT HEART FAILURE

Name_______________________

PULMONARY HYPERTENSION

- ☐ 0) NONE
- ☐ 1) SYMPTOMS (TIREDNESS, SOB, DIZZINESS, FAINTING)
- ☐ 2) CONFIRMED DIAGNOSIS
- ☐ 3) ON MEDS FOR PULMONARY HYPERTENSION (ANTICOAGULANTS OR CALCIUM CHANNEL BLOCKERS)
- ☐ 4) ON STRONGER MEDS OR OXYGEN
- ☐ 5) NEEDS OR HAS LUNG TRANSPLANTATION

ASTHMA

- ☐ 0) NONE
- ☐ 1) INTERMITTENT MILD SYMPTOMS, NO MEDS
- ☐ 2) SYMPTOMS CONTROLLED WITH ORAL INHALERS
- ☐ 3) WELL CONTROLLED WITH DAILY MEDS
- ☐ 4) SYMPTOMS NOT WELL CONTROLLED, ON STEROIDS OR ANTI-CHOLINERGICS
- ☐ 5) HOSPITALIZED WITHIN THE LAST 2 YEARS, HISTORY OF INTUBATION

GASTROINTESTINAL DISEASE

ABDOMINAL HERNIA

- ☐ 0) NONE
- ☐ 1) HERNIA BUT NO SYMPTOMS
- ☐ 2) HERNIA WITH PAIN OR OTHER SYMPTOMS
- ☐ 3) SUCCESSFUL REPAIR OF ABDOMINAL HERNIA
- ☐ 4) RECURRENT ABDOMINAL HERNIA OR HERNIA LARGER THAN 15 CM
- ☐ 5) CHRONIC PROLAPSE THROUGH LARGE HERNIA, OR MULTIPLE OR FAILED HERNIA REPAIRS

GALLSTONES

- ☐ 0) NONE
- ☐ 1) GALLSTONES WITH INTERMITTENT SYMPTOMS
- ☐ 2) GALLSTONES WITH SEVERE SYMPTOMS OR HAD SURGERY FOR GALLBLADDER
- ☐ 3) GALLSTONES WITH COMPLICATIONS REQUIRING EMERGENCY SURGERY BEFORE BARIATRIC SURGERY
- ☐ 4) HISTORY OF GALLBLADDER REMOVAL WITH ONGOING COMPLICATIONS NOT RESOLVED

HEARTBURN/GERD

- ☐ 0) NONE
- ☐ 1) INTERMITTENT SYMPTOMS, NO MEDS
- ☐ 2) INTERMITTENT MEDS
- ☐ 3) H2 BLOCKERS (ZANTAC, TAGAMET, PEPCID) OR LOW DOSE PPI
- ☐ 4) HIGH DOSE PPI (PRILOSEC, NEXIUM, PERVACID PROTONIX TWICE DAILY)
- ☐ 5) MEETS CRITERIA FOR SURGERY OR HAND ANTI-REFLUX SURGERY OR PROCEDURE, HISTORY OF BARRETT'S ESOPHAGUS

HIATAL HERNIA

- ☐ 0) NONE
- ☐ 1) SMALL HERNIA
- ☐ 2) LARGE HERNIA
- ☐ 3) DIFFICULTY SWALLOWING
- ☐ 4) SURGICAL REPAIR OF HIATAL HERNIA

LIVER DISEASE

- ☐ 0) NONE
- ☐ 1) MILD LIVER ENLARGEMENT OR FATTY LIVER, NORMAL LIVER BLOOD TESTS (CATEGORY 1)
- ☐ 2) MODERATE LIVER ENLARGEMENT OR FATTY LIVER, ABNORMAL LIVER BLOOD TESTS (CATEGORY 2)
- ☐ 3) MARKED LIVER ENLARGEMENT OR FATTY LIVER WITH INFLAMMATION OR FIBROSIS (CATEGORY 3)
- ☐ 4) DEFINE NASH, CIRRHOSIS, HEPATIC DYSFUNCTION BY LIVER BLOOD TESTS
- ☐ 5) HEPATIC FAILURE, TRANSPLANT INDICATED OR DONE

MUSCULOSKELETAL

BACK PAIN

- ☐ 0) NONE
- ☐ 1) INTERMITTENT SYMPTOMS NOT REQUIRING TREATMENT
- ☐ 2) SYMPTOMS REQUIRING A NON-NARCOTIC TREATMENT
- ☐ 3) SYMPTOMS REQUIRING NARCOTICS, OBJECTIVE FINDINGS ON EXAM OR STUDY
- ☐ 4) SUCCESSFUL SURGERY ON BACK ALREADY DONE OR PENDING
- ☐ 5) FAILED SURGERY ON BACK WITH CONTINUED EXISTING SYMPTOMS

FIBROMYALGIA

- ☐ 0) NONE
- ☐ 1) TREATED WITH EXERCISE
- ☐ 2) TREATED WITH NON-NARCOTICS MEDS
- ☐ 3) TREATED WITH NARCOTICS
- ☐ 4) SURGERY REQUIRED OR PLANNED
- ☐ 5) DISABLING, TREATMENT NOT EFFECTIVE

JOINT PAIN

- ☐ 0) NONE
- ☐ 1) PAIN WITH WALKING OUT OF HOUSE, NO TREATMENT
- ☐ 2) PAIN WITH WALKING OUT OF HOUSE, REQUIRING NON-NARCOTICS
- ☐ 3) PAIN WITH WALKING AROUND HOUSE
- ☐ 4) SURGERY REQUIRED SUCH AS ARTHROSCOPY
- ☐ 5) NEED OR HAS HAD JOINT REPLACEMENT

FUNCTIONAL STATUS

- ☐ 0) ABLE TO WALK 200 FEET UNASSISTED
- ☐ 1) ABLE TO WALK 200 FEET WITH ASSISTANCE (CANE, WALKER)
- ☐ 2) UNABLE TO WALK 200 FEET
- ☐ 3) UNABLE TO WALK MORE THAN 10 FEET WITH ASSISTANCE

GENERAL

PSUEDOTUMOR CEREBRI (PCT)

- ☐ 0) NONE
- ☐ 1) HEADACHE WITH DIZZINESS, NAUSEA, AND/OR PAIN BEHIND EYES
- ☐ 2) HEADACHES WITH VISUAL SYMPTOMS, OR ON DIURETICS
- ☐ 3) MRI CONFIRMS PCT
- ☐ 4) CONTROLLED WITH STRONGER MEDICATIONS
- ☐ 5) REQUIRES NARCOTICS OR SURGERY DONE OR NEEDED

SKIN/PANNUS

- ☐ 0) NONE
- ☐ 1) SKIN FOLD IRRITATION
- ☐ 2) PANNUS/SKIN FOLDS INTERFERE WITH WALKING
- ☐ 3) RECURRENT CELLULITES, ULCERATION
- ☐ 4) SURGICAL TREATMENT REQUIRED
- ☐ 5) DISABILITY, UNABLE TO WALK