# Medical and Bariatric History

The following information is very important to your health.
Please take the time to fully and completely fill out this important information.

## ***PERSONAL INFORMATION***

Date Form Completed ____/____/____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ❒ Female ❒ Male

Marital Status: ❒ Single ❒ Married ❒Divorced ❒Other: _____

Name of Spouse/Partner/Significant Other:_____

Social Security Number: _____-_____-_____ Drivers License No.: _____ State: _____

*Home Address*: _____
City: _____ State: _____ Zip: _____-_____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Fax: ( ) _____ Email: _____@_____

*Emergency Contact Person*: _____ Relationship: _____ Phone: ( ) _____
Address: _____
City: _____ State: _____ Zip: _____-_____

*Primary Care Physician*: _____ Telephone: ( ) _____ Ext: _____
Address: _____ Fax: ( ) _____
City: _____ State: _____ Zip: _____-_____

*Cardiologist*: _____ Telephone: ( ) _____ Ext: _____
Address: _____ Fax: ( ) _____
City: _____ State: _____ Zip: _____-_____

*Other Physician*: _____ Specialty: _____
Telephone: ( ) _____ Ext: _____
Address: _____ Fax: ( ) _____
City: _____ State: _____ Zip: _____-_____

*Other Physician*: _____ Specialty: _____
Telephone: ( ) _____ Ext: _____
Address: _____ Fax: ( ) _____
City: _____ State: _____ Zip: _____-_____

## ***INSURANCE INFORMATION***

### ***PRIMARY INSURANCE INFORMATION***

Subscribers Name: _____ Relation to Patient: _____
Insurance Company Name:_____
Group #: _____ ID#: _____

### ***SECONDARY INSURANCE INFORMATION***

Subscribers Name: _____ Relation to Patient: _____
Insurance Company Name:_____
Group #: _____ ID#: _____

# ***WEIGHT LOSS HISTORY***

Which parent is/was morbidly obese? ❒Mother ❒ Father
❒ Neither ❒ Do not know biologic parents

I have_____ brothers, _____ of them are morbidly obese.
I have_____ sisters, _____ of them are morbidly obese.

As a child (between the ages of 5 and 10), I was approximately _____ pounds overweight.

As an adolescent (between the ages of 10 and 20), I was approximately _____ pounds overweight.

As an adult, I estimate that my weight has ranged between a low of _____ pounds and a high of _____ pounds.

I began to gain weight at the age of _____.
Please list 3 reasons (if known) for weight gain:
1. _____
2. _____
3. _____

I began to gain weight after pregnancy with my _____ child

My current weight is _____ pounds. My height is _____ feet, _____ inches **BMI:_____**

My goal is to attain a weight of approximately _____ pounds after surgery.

**Office Use Only**

Weight: _____

Height: _____

BMI: _____

Three goals I hope to accomplish as a result of weight loss:
1. _____
2. _____
3. _____

SITUATIONS:

❒ I mostly eat only when I am hungry

❒ I eat more in stressful situations which usually comes from:
❒Work ❒Home ❒Family ❒Other:_____

❒ My spouse, fiancé, partner, significant other is overweight? ❒ Yes ❒ No ❒Not applicable
❒He/She is overweight by ❒20 lbs ❒50 lbs ❒ 100 lbs. ❒>150lbs.

❒ I eat fast food _____/ week.
❒ I eat _____ meals/day.
❒ I have _____ snacks/day.

Please list 3 food cravings: 1. _____ 2. _____ 3. _____

I usually eat for snacks: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

I usually eat for meals: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

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## ***WEIGHT LOSS DIETS / WEIGHT LOSS PROGRAMS***

Please list all dietary and exercise attempts at weight loss or control that have been sustained for at least 3 months in the past 5 years. Include all diets, physician or nutritionist supervised diets, exercise programs, weight loss mediations or supplements.

***BE AS COMPLETE AS POSSIBLE***

| Program or Diet Name | From Month/Yr | To Month/Yr | Amount of Weight Loss | Type of Diet and Reasons for Stopping |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| Have you ever taken Fen-Phen?<br><br>❒ Yes ❒ No | | | | |
| **Previous Weight Loss Surgery?**<br>Type: | When? | Where? | Amount of weight loss after surgery? | Weight at the time of operation?<br><br>Weight gain after weight loss?<br><br>Current Weight? |

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## ***MEDICAL HISTORY***

### ***DIABETES***

❒ I have Diabetes (*complete this section*) ❒ I do **NOT** have Diabetes (*go to next section*)

I was diagnosed in _____(year) at the age of _____.

I have:

- ❒ Type I or Insulin Dependent Diabetes
- ❒ Type II or Non-Insulin Dependent Diabetes
- ❒ I had Gestational Diabetes (Diabetes only when pregnant)

I take the following medicines to control my Diabetes:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### ***HIGH BLOOD PRESSURE***

❒ I have High Blood pressure (*complete this section*) ❒ I do **NOT** have High Blood Pressure (*go to next section*)

I was diagnosed in _____(year) at the age of _____.

I take the following medicines to control my High Blood Pressure:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### ***HEART DISEASE*** ***(Coronary Artery Disease/Congestive Heart Failure/Heart Attack/Myocardial Infarction (MI)/Chest Pain/Angina)***

❒ I have Heart Disease (*complete this section*) ❒ I do **NOT** have or have never had Heart Disease (*skip to next section*)

My specific heart condition is: _____
I was diagnosed in _____(year) at the age of _____.

| | | |
|---|---|---|
| I have had a heart attack (MI) | Date ____/____/____ | Date ____/____/____ |
| I have undergone angioplasty | Date ____/____/____ | Hospital: _____ |
| I have had heart bypass surgery | Date ____/____/____ | Hospital:_____ |

Other medical complications I have had or have that are due to the effects of Heart Disease include:

_____
_____

I take the following medicines for my Heart Disease:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### ***HIGH CHOLESTEROL***

❒ I have High Cholesterol (*complete this section*) ❒ I do **NOT** have High Cholesterol (*skip to next section*)

I was diagnosed in _____(year) at the age of _____.

I take the following medicines for my Elevated Blood Lipids:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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## ***GALLSTONES/PREVIOUS REMOVAL OF GALLBLADDER***

❒ I have Gallstones (*complete this section*) ❒ I do **NOT** have Gallstones (*answer next **question***)

❒I have had my Gallbladder removed (*complete this section*) ❒ I have **NOT** had my Gallbladder removed (*skip to next section*)

❒I was diagnosed with gallstones _____(year) at the age of _____.

My gallbladder was removed ❒ through an "open" or "large" incision in _____ (year).
❒ Laparoscopically in _____ (year).

## ***HEARTBURN/REFLUX/GASTRO-ESOPHAGEAL REFLUX DISEASE/GERD***

❒I have Heartburn (*complete this section*) ❒I do **NOT** have Heartburn (*skip to next section*)

I was diagnosed in _____(year) at the age of _____.

I have had the following tests/exams to evaluate my Heartburn

❒ X-Rays (Barium Swallow, CT, MRI) When? ____/____/____
❒ An endoscopy was performed (a camera looked in my esophagus and stomach) When? ____/____/____
❒ I have been told that I have "**Barrett's Esophagus**" When? ____/____/____
❒ I had a 24-Hour pH Study When? ____/____/____

I have already had a surgical procedure for my heartburn on (*month*) _____ / (*year*): Type:_____

I take the following medicines for my Reflux:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***FEMALE HORMONAL PROBLEMS***

***Dysmenorrhea** (Irregular or difficult menstrual periods)*
***Hirsutism** (Excessive growth of body hair, especially on the face)*
***Infertility** (Inability to become pregnant)*

❒I have Female Hormonal Problems (*complete this section*) ❒I do **NOT** have Female Hormonal Problems (*skip to next section*)

My specific condition or conditions is/are:

❒ Infertility
❒ Excess hair growth particularly on the face
❒ Irregular menstrual periods
❒Absence of menstrual periods

I was diagnosed in _____(year) at the age of _____.

## ***ARTHRITIS***

❒I have Arthritis (*complete this section*) ❒ I do **NOT** have Arthritis (*skip to next section*)

My specific condition is: _____
My arthritis affects my (list joints or areas):_____
I was diagnosed in _____(year) at the age of _____.

I take the following medicines for Arthritis:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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## ***PULMONARY DISEASE*** *(Lung Problems/Breathing Problems/Sleep Apnea/Asthma/Obesity Hypoventilation)*

❒I have Pulmonary Disease (*complete this section*) ❒I do **NOT** have Pulmonary Disease (*skip to next section*)

My specific lung or breathing condition is: _____
I was diagnosed in _____(year) at the age of _____.

❒ I have been recommended to undergo a Sleep Apnea Evaluation
❒ I underwent a Sleep Apnea Evaluation When? _____ Where? _____
❒ I use a BiPAP or CPAP machine: ❒Every night, ❒Most nights, ❒Some nights, ❒Never

I currently or used to see Dr. _____ for my Pulmonary Disease.
Specialty:_____
Address:_____

I take the following medicines for my Lung or Breathing Disease:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***STRESS URINARY INCONTINENCE*** *(UrinaryLeakage/Incontinence)*

❒I have Stress Urinary Incontinence (*complete this section*) ❒ I do **NOT** have Stress Urinary Incontinence (*skip to next section*)

I was diagnosed in _____(year) at the age of _____.

❒ I have **not** had a specific evaluation for my Stress Urinary Incontinence.

I currently or used to see Dr. _____ for my Stress Urinary Incontinence.
Specialty:_____
Address:_____

❒ Surgery has been recommended for my Incontinence
❒ I had surgery for my Bladder Incontinence on (*month*) _____ / (*year*) _____
Procedure Name or Description: _____

I take the following medicines for my Bladder Incontinence:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***SKIN INFECTIONS*** *(Fungal/Yeast or other Skin infections)*

❒I have Skin Infections (*complete this section*) ❒ I do **NOT** have or have never had Skin Diseases (*skip to next section*)

I was diagnosed in _____(year) at the age of _____.

Part of the body affected? _____ How often? _____ How treated? _____
Part of the body affected? _____ How often? _____ How treated? _____
Part of the body affected? _____ How often? _____ How treated? _____

I take the following medicines for Skin Infections:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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## ***BLOOD DISEASE (Bleeding/ /Deep Vein Thrombosis (DVT) / Pulmonary Embolus / Blood Clots)***

❒ I have or had Bleeding, Blood Clots, or Blood Disease (*complete this section*)
❒ I do **NOT** have Bleeding, Blood Clots, or Blood Disease (*skip to next section*)

My specific blood or bleeding condition is: _____
I was diagnosed in _____(year) at the age of _____.

I have had blood clots form in my legs
❒ When: _____

❒ I have had episodes of excessive bleeding
❒ I have had excessive bleeding after surgical or dental procedures
❒ I have had blood transfusions in the past

Please describe circumstances if any previous box was checked: _____
_____

I take the following medicines for Vein/Blood Disease:

| *Medicine* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***PSYCHIATRIC CONDITION***

❒I have a Psychiatric Condition (*complete this section*) ❒ I do **NOT** have a Psychiatric Condition (*skip to next section*)
❒I have attempted to commit suicide ❒ I have **NEVER** attempted to commit suicide

My specific psychiatric condition is: _____
I was diagnosed in _____(year) at the age of _____.

I currently or used to see Dr. _____ for my Psychiatric Condition.
Specialty:_____
Address:_____

❒I have been in therapy Began: ___/___/___ Continuing ❒Yes ❒ No Stopped When ____/____/___
❒ I have been admitted to a hospital for psychiatric care or evaluation. When? _____ Where? _____
Why? _____

I take the following medicines for my Psychiatric Condition:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***CANCER (Tumor/Malignancy)***

❒I had Cancer (*complete rest of section*) ❒ I **NEVER** had Cancer (*skip to next section*)

My type of Cancer is/was: _____
I was diagnosed in _____(year) at the age of _____.

I had an operation for my cancer in _____ (year) at age _____.
The surgical performed was: _____ _____

❒ I underwent Radiation Therapy for my cancer: ❒ Before Surgery ❒ After Surgery ❒Only Radiation – no surgery
❒ I underwent Chemotherapy for my cancer. ❒ Before Surgery ❒ After Surgery ❒Only Chemotherapy – no surgery

I take the following medicines for my Cancer:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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## ***RESTRICTED ACTIVITIES OF DAILY LIVING (Lifestyle Limitations due to Obesity)***

❒ I have suffered from Restricted Activities of Daily Living since (year) _____ or since I have weighed approximately _____ pounds

❒ I do **NOT** have or have never had Restricted Activities of Daily Living or Lifestyle Limitations

## ***KIDNEY DISEASE (Renal Insufficiency/Diabetic Renal Problems)***

❒I have Kidney Disease (*complete this section*) ❒I do **NOT** have Kidney Disease (*skip to next section*)

My specific kidney disease is: _____
I was diagnosed in _____(year) at the age of _____.

I currently or used to see Dr. _____ for my Kidney Disease.
Specialty:_____
Address:_____

My Kidney Disease is due to:

❒ High Blood Pressure ❒ Diabetes

❒ Due to another medical condition: _____

I take the following medicines for my Kidney Disease:

| *Medication* | *Dosage/milligrams* | *Times per Day* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***OTHER MEDICAL PROBLEMS***

| **Condition** | **Year Diagnosed** | **Treatment (Medicine/Surgery)** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## ***SURGICAL HISTORY***

| Procedure | Year and Age | Incision | Other |
|---|---|---|---|
| Appendectomy | _____/_____ | ❒Laparoscopic ❒Incision | _____ |
| Gallbladder Removal | _____/_____ | ❒Laparoscopic ❒Incision | _____ |
| Groin Hernia | _____/_____ | ❒Laparoscopic ❒Incision | Mesh ❒ Yes ❒No |
| Umbilical Hernia | _____/_____ | ❒Laparoscopic ❒Incision | Mesh ❒ Yes ❒No |
| Other Hernia:_____ | _____/_____ | ❒Laparoscopic ❒Incision | Mesh ❒ Yes ❒No |
| Hysterectomy | _____/_____ | ❒Laparoscopic ❒Incision | _____ |
| Other | | | |
| _____ | _____/_____ | _____ | _____ |
| _____ | _____/_____ | _____ | _____ |

I have had general anesthesia (a breathing tube placed down throat) in the past? ❒ Yes ❒ No
I experienced a complication/problem form general anesthesia? ❒ Yes ❒ No
If yes, please describe? _____
_____

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## ***MEDICATIONS***

(*Please list **ALL** prescription medications, non-prescription medication, and herbal medication **EVEN IF LISTED PREVIOUSLY***)

| Medication | Dose (mg or #) | Times per day | For What Condition? |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**I currently take:**

❒ **Aspirin** ❒ **Heparin (Lovenox, Fragmin)** ❒ **NSAIDS (Motrin, Advil)**
❒ **Coumadin** ❒ **Plavix** ❒ **Vioxx, Celebrex, Bextra**

## ***ALLERGIES***

I am ALLERGIC to the following medicines:

| Medication | Allergic Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

❒ Besides medicine, I am allergic to the following:

| Product | Allergic Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

❒ I HAVE NO KNOWN DRUG OR OTHER ALLERGIES

## ***PREVIOUS HOSPITALIZATIONS***

| When? | Where? | Why? |
|---|---|---|
| ____/____/____ | _____ | _____ |
| ____/____/____ | _____ | _____ |
| ____/____/____ | _____ | _____ |

## ***SOCIAL HISTORY***

### *SMOKING*

I currently smoke ❒Yes ❒No
I smoke _____ packs/day for the past _____ years

I smoked in the past ❒Yes ❒No
I smoked _____ packs/day for the past _____ years

### *DRINKING*

Do you drink now or have you in the past ❒Yes ❒No
I have _____drinks/ week of _____ (beer/wine/etc…)
I stopped drinking _____(month)/_____(year).

My drinking has led to problems with family/work/friends ❒Yes ❒No

I have had blackouts or memory loss from drinking ❒Yes ❒No

I have felt that I had a problem and needed to stop drinking ❒Yes ❒No

I have/ had a problem in the past with alcohol abuse (alcoholism) ❒Yes ❒No

I was addicted from (month) _____ to (year) _____

I stopped because: _____
I was able to stop:
❒ On my own ❒ Program such as AA ❒ I was admitted to a Rehabilitation Center

### *DRUG USE*

I currently use drugs ❒Yes ❒No
I have been using _____ for the past _____ year(s).

I have used drugs in the past. ❒Yes ❒No
I have used _____ from _____ to_____ (years).
I have used _____ from _____ to_____ (years).

I was/am currently addicted to: _____
I was addicted from (month) _____ to (year) _____

I stopped because: _____
I was able to stop:
❒ On my own ❒ Program such as NA ❒ I was admitted to a Rehabilitation Center

❒ I think I currently have a problem controlling my use of the following substances: _____

## The above is true and correct to the best of my knowledge.

_____

## Patient's Signature

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