Patient Name:_____ ❑Male ❑Female Date of Birth:_____ Age:_____

Height:_____feet _____inches Current Weight:_____lbs Highest Weight:_____lbs – when?_____ Weight at age 18: _____lbs

I am interested in: ❑Adjustable Gastric Band ❑Gastric Bypass ❑Sleeve Gastrectomy ❑Revision of previous bariatric surgery ❑Unsure

Occupation: _____

❑Full-time (more than 35 hours) ❑Part-time (less than 35 hours) ❑Unemployed ❑Disabled ❑Retired
❑Self-employed ❑Homemaker ❑Student

SOCIAL HISTORY:

Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widow ❑Significant Other

❑Yes ❑No Do you have children? If yes, how many do you have? _____

❑Yes ❑No Do you have grandchildren? If yes, how many do you have? _____

❑Yes ❑No Have you ever used tobacco products?
If yes, did you use (check all that apply): ❑Cigarettes ❑Cigars ❑Pipe ❑Chewing tobacco

❑Yes ❑No Do you *currently* use tobacco products?

❑Yes ❑No Have you ever used illegal or street drugs?
If yes, how often did you use? ❑Rarely ❑Occasionally ❑Frequently Have you stopped using? ❑Yes ❑No

❑Yes ❑No Do you drink alcohol? If yes, how often do you drink? ❑Rarely ❑Occasionally ❑Frequently

❑Yes ❑No Have you ever had an addiction problem that required treatment or rehab? If yes, please check all that apply:
❑Alcohol ❑Illegal (street) drugs ❑Prescription drugs ❑Other addiction(s):_____

FAMILY HISTORY:

Father's present age:_____ ***or*** Age at death:_____ Cause of death:_____ Health problems:_____

Mother's present age:_____ ***or*** Age at death:_____ Cause of death:_____ Health problems: _____

How many brothers and/or sisters do you have in your family?_____

Do you have a family history of (check all that apply):
❑Obesity ❑Heart disease ❑Blood clotting or bleeding disorders ❑Diabetes ❑High blood pressure ❑Pulmonary embolus
❑Breast Cancer ❑Colon cancer ❑Lung disease, asthma, emphysema ❑Malignant hyperthermia ❑Gastric cancer

ENDOCRINE:

❑Yes ❑No Have you been told that you are pre-diabetic or have high blood sugars?

❑Yes ❑No Do you currently have diabetes?

❑Yes ❑No Do you take insulin?

❑Yes ❑No Do you take oral diabetic medication?

❑Yes ❑No Do you use diet only to treat your diabetes?

❑Yes ❑No Do you take medication for thyroid disease?

❑Yes ❑No Have you ever used steroids for any medical problem(s) in the past year?

❑Yes ❑No Have you ever been diagnosed with sickle cell disease or trait?

❑Yes ❑No Are you HIV positive or do you AIDS?

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

Patient Name: _____
Patient ID Number: _____
DOB: _____

CARDIAC:

❑Yes ❑No Have you been under the care of a heart specialist (cardiologist) in the last 5 years?

❑Yes ❑No Do you have high blood pressure?

❑Yes ❑No Do you take medication for high blood pressure?

❑Yes ❑No Have you seen a doctor for irregular heartbeats?

❑Yes ❑No Do you take medication for irregular heartbeats?

❑Yes ❑No Have you been told that you have a heart murmur?

❑Yes ❑No Have you been told that you have mitral valve prolapsed?

❑Yes ❑No Do you currently have chest pain(angina)?
If yes, do you have chest pain: ❑While sitting still
❑While walking ❑With strenuous work/exercise

❑Yes ❑No Have you ever had a heart attack?

❑Yes ❑No Have you ever had an abnormal EKG heart tracing)?

❑Yes ❑No Have you ever had a cardiac (heart) catheterization?

❑Yes ❑No Have you ever had a heart treadmill or chemical stress test?

❑Yes ❑No Have you ever been told that you have congestive heart failure?

❑Yes ❑No Have you ever been hospitalized for heart failure?

❑Yes ❑No Have you ever had an angioplasty or cardiac stents placed for your heart disease?

❑Yes ❑No Are you on blood thinner medication for treatment of your heart disease?

❑Yes ❑No Do you have leg, ankle, or feet swelling?

❑Yes ❑No Are you on medication for leg, ankle, or feet swelling?

❑Yes ❑No Have you ever had blood clots in your legs (DVT)?
❑Yes ❑No If yes, were you treated with blood thinners?

❑Yes ❑No Have you ever had blood clots in your lungs (pulmonary embolus)?
❑Yes ❑No If yes, were you treated with blood thinners?

❑Yes ❑No Have you been treated for leg, ankle, or foot ulcers (venous status ulcers)?

❑Yes ❑No Do you have varicose veins? If yes:
❑Right leg ❑Left leg ❑Both legs

❑Yes ❑No Have you ever had an IVC filter placed for blood clots?

❑Yes ❑No Have you ever had a stroke?

❑Yes ❑No Have you ever been told that your cholesterol level was high?

❑Yes ❑No Do you take medication for high cholesterol levels?

❑Yes ❑No Have you ever been told that you have high triglyceride levels?

❑Yes ❑No Do you take medication for high triglyceride levels?

1. Have you ever had a cardiac cath? ❑Yes ❑No

   If Yes: Was a stent or balloon used to open the arteries (Angioplasty) or modifications to the catheter tip done to cut out plaque? ❑Yes ❑No

2. Have you ever had a major cardiac surgery (off pump or bypass) which includes the following (check if you have):
   - ❑CABG (Coronary Artery Bypass Graft)
   - ❑Valve repair or replacement
   - ❑Repair of atrial or ventricular septal defects
   - ❑Great thoracic vessel repair
   - ❑Cardiac (heart) transplant
   - ❑Left ventricular Aneurysmectomy
   - ❑Insertion of ventricular assist devices (LVAD, BiVad)

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

Patient Name: _____

Patient ID Number: _____

DOB: _____

PULMONARY (LUNGS):

❑Yes ❑No Have you been under the care of a lung specialist (pulmonologist) in the last 2 years?

❑Yes ❑No Do you get short of breath walking up a flight of steps?

❑Yes ❑No Do you get short of breath walking a city block?

❑Yes ❑No Do you have a history of bronchitis?

❑Yes ❑No Do you have asthma? If yes:

- ❑Yes ❑No Do you inhaler daily?
- ❑Yes ❑No Do you use inhalers only when needed?
- ❑Yes ❑No Do you use nebulizer treatments?
- ❑Yes ❑No Do you use oxygen?
- ❑Yes ❑No Have you been hospitalized for asthma within the last 2 years?
- ❑Yes ❑No Is your asthma well controlled?

❑Yes ❑No Do you have a chronic cough?

❑Yes ❑No Have you ever been diagnosed with tuberculosis?

❑Yes ❑No Have you ever been diagnosed with COPD?

❑Yes ❑No Have you ever been diagnosed with sleep apnea? If yes:

- ❑Yes ❑No Do you use an oral appliance?
- ❑Yes ❑No Do you use a CPAP machine?
- ❑Yes ❑No Do you use a BiPAP machine?
- ❑Yes ❑No Do you use nighttime oxygen?
- ❑Yes ❑No Have you had surgery for the treatment of sleep apnea?

❑Yes ❑No Do you snore when you sleep?

❑Yes ❑No Do you wake up at night trying to catch your breath?

❑Yes ❑No Do you wake up frequently with a headache?

❑Yes ❑No Do you wake up from your sleep to urinate nightly?

❑Yes ❑No Do you routinely sleep in a recliner chair at night?

❑Yes ❑No Have you ever been diagnosed with emphysema?

❑Yes ❑No Have you ever been diagnosed with sarcoidosis?

BONES / JOINTS / MUSCLES:

❑Yes ❑No Have you ever been diagnosed with arthritis? If yes, which one?

❑Rheumatoid arthritis ❑Degenerative joint disease
❑Osteoarthritis ❑Other arthritis (not listed)

❑Yes ❑No Do you have hip pain that limits your activity level?
If yes: ❑Right ❑Left ❑Both

❑Yes ❑No Do you have knee pain that limits your activity level?
If yes: ❑Right ❑Left ❑Both

❑Yes ❑No Do you have ankles pain that limits your activity level?
If yes: ❑Right ❑Left ❑Both

❑Yes ❑No Do you have shoulder pain that limits your activity level?
If yes: ❑Right ❑Left ❑Both

❑Yes ❑No Do you have frequent back pain which limits your activity level?

❑Yes ❑No Have you ever been diagnosed with gout? If yes:

- ❑Yes ❑No Do you currently take medication(s) for gout?

❑Yes ❑No Do you use a cane or walker to help you walk?
If yes: ❑Sometimes ❑Always

❑Yes ❑No Do you use a motorized scooter or wheelchair?
If yes: ❑Sometimes ❑Always

❑Yes ❑No Have you ever been diagnosed with herniated disc(s)?

❑Yes ❑No Have you ever been told you have carpal tunnel disease?

❑Yes ❑No Have you ever been diagnosed with scleroderma?

❑Yes ❑No Have you ever been diagnosed with fibromyalgia? If yes, how is it treated:

- ❑Exercise
- ❑Surgical intervention done or recommended
- ❑Non-narcotic medications
- ❑Disabling, no treatment has been effective

❑Yes ❑No Have you ever been diagnosed with lupus?

❑Yes ❑No Are you currently under the care of an orthopedic surgeon or neurosurgeon?

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

Patient Name: _____

Patient ID Number: _____

DOB: _____

GI (STOMACH / INTESTINES):

❑Yes ❑No Have you seen a GI specialist (gastroenterologist) in the past 2 years?

❑Yes ❑No Do you have frequent difficulty chewing or swallowing?

❑Yes ❑No Do you suffer from difficulty having bowel movements (constipation)?

❑Yes ❑No Do you use stool softeners routinely?

❑Yes ❑No Do you have frequent loose stools (diarrhea)?

❑Yes ❑No Do you use anti-diarrhea medication routinely?

❑Yes ❑No Do you or have you had hemorrhoids?

❑Yes ❑No Do you suffer from heartburn (acid reflux)?

❑Yes ❑No Do you routinely take over the counter medications for heartburn?

❑Yes ❑No Do you take prescription medications for heartburn (GERD)?

❑Yes ❑No Have you ever been told that you have a hiatal hernia (hernia in diaphragm)?

❑Yes ❑No Have you ever had a stomach or duodenal ulcer?

❑Yes ❑No Have you ever been diagnosed with irritable bowel syndrome?

❑Yes ❑No Are you lactose intolerant?

❑Yes ❑No Have you ever been diagnosed with Crohn's disease?

❑Yes ❑No Have you ever been diagnosed with ulcerative colitis?

❑Yes ❑No Have you ever been diagnosed with cirrhosis?

❑Yes ❑No Have you ever been diagnosed with a fatty liver?

❑Yes ❑No Have you ever been diagnosed with hepatitis?

❑Yes ❑No Have you ever been diagnosed with celiac sprue?

❑Yes ❑No Have you ever been treated for pancreatitis?

❑Yes ❑No Have you ever had a previous weight-loss surgery?

HEENT / NEURO (HEAD):

❑Yes ❑No Do you have frequent headaches or migraines?

❑Yes ❑No Do you suffer from hearing loss? If yes:
❑Right ❑Left ❑Both

❑Yes ❑No Do you wear glasses, contacts or use reading glasses?

❑Yes ❑No Do you suffer from chronic balance problems (vertigo)?

❑Yes ❑No Have you ever had a seizure?

❑Yes ❑No Are you currently taking any medications to prevent seizures?

❑Yes ❑No Have you ever been diagnosed with multiple sclerosis (MS)?

❑Yes ❑No Have you ever been diagnosed with pseudotumor cerebri? If yes:

- ❑Yes ❑No Do you have nausea and dizziness with headaches?
- ❑Yes ❑No Do you have vision problems when you have your headaches?
- ❑Yes ❑No Have you ever had an MRI to confirm pseudotumor cerebri?
- ❑Yes ❑No Do you use diuretics for treatment of your pseudotumor cerebri?
- ❑Yes ❑No Do you require narcotic medications for pseudotumor cerebri?
- ❑Yes ❑No Has surgical treatment been recommended for you? If yes...
- ❑Yes ❑No Have you received surgical treatment?

CANCER:

❑Yes ❑No Have you ever been diagnosed with a cancer other than skin cancer? If yes, what kind of cancer:

_____

BLADDER / KIDNEY:

❑Yes ❑No Do you have to urinate frequently?

❑Yes ❑No Do you have pain with urination?

❑Yes ❑No Do you have blood in your urine?

❑Yes ❑No Have you been told that you have protein in your urine?

❑Yes ❑No Have you ever had a kidney stone?

❑Yes ❑No Do you have leakage of urine with laughing/coughing/sneezing? If yes:

- ❑Occurs less than once per week
- ❑Greater than one occurrence per week
- ❑Occurs daily
- ❑Is disabling

❑Yes ❑No Do you have leaking of stool (feces) with laughing/coughing/sneezing?

❑Yes ❑No Have you ever had a bladder infection (UTI)?

❑Yes ❑No Have you ever had a kidney infection?

Patient Name: _____

Patient ID Number: _____

DOB: _____

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

PSYCHOLOGICAL:

❑Yes ❑No Have you ever been diagnosed with depression? If yes:

- ❑Yes ❑No Do you require medications for your depression?
- ❑Yes ❑No Is your depression occasional or episodic?
- ❑Yes ❑No Does your depression prevent you from caring for yourself?
- ❑Yes ❑No Does your depression prevent you from keeping a job?
- ❑Yes ❑No Have you ever required hospitalization for depression?
- ❑Yes ❑No Are you currently receiving care by a psychologist, psychiatrist or therapist for your depression?
- ❑Yes ❑No Is your depression being treated by your family doctor?

❑Yes ❑No Have you ever been diagnosed with anxiety/panic attacks? If yes:

- ❑Yes ❑No Do you require medications for anxiety?
- ❑Yes ❑No Is your depression only occasional or episodic?
- ❑Yes ❑No Does your anxiety prevent you from maintaining employment?
- ❑Yes ❑No Have you ever required hospitalization for anxiety?
- ❑Yes ❑No Are you currently receiving care by a psychologist, psychiatrist or therapist for your anxiety?
- ❑Yes ❑No Is your anxiety being treated by your family doctor?

❑Yes ❑No Have you ever been diagnosed with having a bipolar disorder? If yes:

- ❑Yes ❑No Do you require medications for your bipolar disorder?
- ❑Yes ❑No Does your bipolar disorder prevent you from caring for yourself?
- ❑Yes ❑No Does your bipolar disorder prevent you from keeping a job?
- ❑Yes ❑No Have you ever required hospitalization for bipolar disorder?
- ❑Yes ❑No Are you currently receiving care by a psychologist, psychiatrist or therapist for your bipolar disorder?
- ❑Yes ❑No Is your bipolar disorder being treated by your family doctor?

❑Yes ❑No Have you ever been diagnosed with schizophrenia or any other from of personality disorder or mental illness?

❑Yes ❑No Have you been hospitalized for any form of mental illness or breakdown?

GYN (FOR WOMEN ONLY):

❑Yes ❑No Have you ever had a fertility workup?

❑Yes ❑No Are you currently pregnant?

❑Yes ❑No Do you have monthly periods?

❑Yes ❑No Are your periods irregular?

❑Yes ❑No Do you have abnormality heavy or prolonged menstrual periods?

❑Yes ❑No Have you ever been pregnant?
If yes, during any pregnancy, did you have:

- ❑Yes ❑No Diabetes
- ❑Yes ❑No Low iron levels
- ❑Yes ❑No High blood pressure
- ❑Yes ❑No Pre-eclampsia

❑Yes ❑No Are you currently going through or in menopause?

❑Yes ❑No Are you currently using oral contraceptives?

❑Yes ❑No Are you currently using any other form of contraception?

❑Yes ❑No Have you ever been diagnosed with polycystic ovarian disease (PCOS)? If yes:

- ❑Yes ❑No Are you being treated with oral contraceptives?
- ❑Yes ❑No Are you being treated with metformin?
- ❑Yes ❑No Are you being treated with any other medication(s)?
- ❑Yes ❑No Have you been told you are infertile?

❑Yes ❑No Have you had a Pap test done in the last 2 years?

❑Yes ❑No Have you ever had an ectopic pregnancy?

❑Yes ❑No Do you receive a gynecological exam yearly?

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

Patient Name: _____

Patient ID Number: _____

DOB: _____

SURGICAL HISTORY:

Have you ever had any of the following types of surgery (check all that apply):

- ❑ Anti-reflux procedure
- ❑ Appendix removed (appendectomy)
- ❑ Bowel resection
- ❑ Breast cancer biopsy
- ❑ Breast cancer mastectomy (breast removal)
- ❑ Breast cancer radiation
- ❑ Gallbladder removal (cholecystectomy)
- ❑ Open heart surgery
- ❑ Hysterectomy
- ❑ Hip replacement
- ❑ Knee replacement
- ❑ Laminectomy (spine decompression)
- ❑ Removal of a back disc (discectomy)
- ❑ Nissen fundoplication
- ❑ Peripheral vascular (blood vessels in arms and legs) procedures
- ❑ Tubal ligation
- ❑ Vagotomy (division of vagus nerve)
- ❑ Vasectomy

Other surgeries not listed above (include any biopsy or cosmetic surgery/procedure):

CURRENT MEDICATIONS:

Please list any prescription medications that you are currently taking:

Name of Medication	Dosage Instruction	Reason for Medication

ALLERGIES:

Are you allergic to any medications? If yes please list the allergy and any adverse reaction, such as hives, rash, shortness of breath or anaphylaxis.

Allergy	Type of Reaction	Allergy	Type of Reaction

❑ Yes ❑ No Do you have a latex allergy?

❑ Yes ❑ No Are you allergic to shellfish, iodine or contrast dye?

Patient Name: _____

Patient ID Number: _____

DOB: _____

GENERAL SURGERY
BARIATRIC
NEW PATIENT HISTORY

OVER-THE-COUNTER AND HERBAL PRODUCTS:

Please list any over-the-counter (OTC) medications or herbals that you are currently taking:

Name of OTC / Herbal	Dosage	Reason

WEIGHT LOSS MEDICATION HISTORY:

Please indicate if you have taken any of the following medications to lose weight:

Name of Medication	Dates	Duration	Weight Loss
Amphetamines			
Phentermine (Adipex, Fastin)			
Phen-Fen			
Dexfenfluramine (Redux)			
Xenical (Orlistat)			
Meridia (Sibutramine)			
Liraglutide (Saxenda)			
Naltrexone-Bupropion (Contrave)			
Phentermine-Topiramate (Qsymia)			
Lorcaserin (Belviq)			
Other Diet Medication:_____			

NON-DIETARY THERAPIES:

Please indicate if you have tried any of the following weight loss therapies:

Therapy	Dates	Duration	Weight Loss
Exercise			
Hypnosis			
Acupuncture			
Other:_____			

PREVIOUS WEIGHT LOSS SURGERY: ❑Yes ❑No

Surgery Type	Date	Surgeon	Weight Loss

What is the reason you are seeking weight loss surgery? _____

_____

_____

How much weight do you expect to lose? _____

Patient Name: _____

Patient ID Number: _____

DOB: _____