PATIENT HEALTH HISTORY FORM:

It is very important to know your detailed medical history information to assess your health. Obesity and its associated diseases and risk factors increase mortality and surgical complications. **We rely on the information you provide; therefore it is imperative for safety and insurance purposes that a detailed medical history be completed.**

Metabolic and Bariatric Surgery has strict requirements.

- **NO tobacco products are permitted for 8 weeks before surgery-**
  - **This gives your lungs a chance to better provide oxygen to your blood, which can help decrease the risk of infection, pneumonia, and especially improve wound healing.**
- **Second hand smoke is also irritating to the lungs.**
  - **Causing the above risks and should be avoided.**
- **We will not operate on any patient that is an active smoker.**
  - **May be require to take a laboratory test to confirm you are smoke free.**

PATIENT STATEMENT

I am aware that Bariatric or Weight-loss surgery is not a "quick fix" but rather a tool for controlling weight, combined with exercise and proper nutrition. I am aware that I will be expected to follow up post op on a regular basis, and be required to take vitamins, and supplements for the rest of my life. I am also aware that reversal of this surgery is not recommended. The information on my medical history form is true and correct to the best of my belief.

Height: _____ Weight: _____ Birth date: _____

Name: _____

Patient's signature: _____ Date: _____

Employment status: Full Time/Part Time/Unemployed/Retired

I am interested in ***Please circle one*****:** Sleeve Gastrectomy/Gastric Bypass/ORBERA/Unsure

How did you hear about us?

_____

WEIGHT LOSS HISTORY

It is CRITICAL and IMPERATIVE to document any evidence of previous weight loss attempts which is a requirement from the insurance companies. Please fill out the details and include the dates, length of time of each diet, and outcomes to the best of your knowledge. Start with the most current.

Year: _____, How long were you on this diet: _______, Weight at start of this diet: ______,
Weight lost on this diet: _____, Type of Diet/ Weight Loss Program:_____________________________,
Supervised by Dr. or Dietician: YES / NO

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Weight lost on this diet: _____, Type of Diet/ Weight Loss Program:_____________________________,
Supervised by Dr. or Dietician: YES / NO

Year: _____, How long were you on this diet: _______, Weight at start of this diet: ______,
Weight lost on this diet: _____, Type of Diet/ Weight Loss Program:_____________________________,
Supervised by Dr. or Dietician: YES / NO

EXAMPLES OF WEIGHT LOSS METHODS:

1. Supervised Diets: Medifast, Optifast, Nutri System, Weight Watchers, Overeaters Anonymous
2. NON-Supervised Diets: Slimfast, Calorie counting, Low Fat, Atkins diet, Hypnosis.
3. Weight Loss Medications.

CARDIOVASCULAR

Heart problems: YES / NO,
If yes please describe;_____
Chest pains: YES /NO
If yes; How Long?_____
How do you relieve the chest pain? _____
Previous Heart Attack: YES / NO
If yes when? _____Did you require surgery? _____
Heart Stents? _____ How many? _____ How long ago? _____
High blood pressure: YES / NO
Are you on medication if so what? _____
Previous Blood Clot or PE: YES / NO, if yes when? _____
Shortness of Breath:
At rest? YES / NO
With activity? YES / NO, How long before getting short of breath? _____
High cholesterol: YES / NO
High triglycerides: YES / NO
Feel tired all the time: YES / NO

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times.
Use the following scale to choose the most appropriate number for each situation.

0= would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting, inactive, in a public place (e.g: a theatre or a meeting)	
As a passenger in a car for over an hour without a break	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

Score:
0-10: Normal Range
10-12: Borderline
12-24: Abnormal
Have you had a Sleep Study Test? Yes/No or Are you scheduled for a Sleep Study Test? YES / NO
Do you currently use or have you previously been prescribed a CPAP or BiPAP machine? Yes/No

DIABETES AND ENDOCRINE SYSTEM

Have you been diagnosed with Diabetes Mellitus? YES / NO, if yes what type? Type 1 / Type 2

If yes to the above questions please answer the following.
When your diabetes was first diagnosed? _____
Are you taking oral medications? YES / NO If yes what? _____
Are you taking insulin? YES / NO
Does your diabetes resolve with weight loss? YES / NO
Have you been told you are Pre-diabetic or borderline diebetic? YES / NO
Have you ever had Gestational Diabetes? YES / NO
How old were you at the time? _____
History of Hypoglycemia? YES / NO

Thyroid problems (requiring medication)
Hyperthyroid? YES / NO
Hypothyroid? YES / NO

GASTROINTESTINAL

Do you have gallstones that was diagnosed by ultrasound? YES / NO
Have you had your gallbladder removed? YES / NO, if yes, laparoscopically or open.
Have you had stomach ulcers? YES / NO
Have you taken medicine for ulcers? YES / NO
Do you or have you had heartburn? YES / NO
How often do you have heartburn, _____, and do you take medications for it? YES / NO

RESPIRATORY

Asthma: *YES or NO*
Last attack? _____

COPD: *YES or NO*
Last attack? _____

Bronchitis: *YES or NO*
Last attack? _____

Pneumonia: *YES or NO*
Last attack? _____

Have you ever had Blood clots in lungs? YES / NO, if yes when? _____
Have you ever had Blood clots in legs? YES / NO, if yes when? _____

MUSCULOSKELETAL

	MILD	MODERATE	SEVERE
Hip Pain			
Knee Pain			
Ankle Pain			
Feet Pain			
Back Pain			
Neck Pain			
Arthritis			

Do you have swelling of your legs? YES / NO
Do you have swelling of your feet? YES / NO
Do you have varicose veins? YES / NO
Have you had ulcers of the leg? YES / NO
Do you use anti-inflammatory medicine? YES / NO, if yes what, _____
Do you use pain medicine? YES / NO, if yes what, and how often, _____

KIDNEY & BLADDER

Do you have renal insufficiency? YES / NO
Renal Failure? YES / NO
Have you had bladder or kidney infections? YES / NO
Have you had kidney stones? YES / NO

BLOOD

Have you ever had a bleeding problem? YES / NO
Have you ever had low platelets? YES / NO
Have you ever had a blood transfusion? YES / NO

NEURO-PSYCHIATRIC

Depression/Anxiety because of obesity? YES / NO
Requiring medication? YES / NO, If yes what kind? _____
Seizures YES / NO
Requiring Medication? YES / NO, If yes what kind? _____
Severe headaches? YES / NO
Requiring Medication? YES / NO, If yes what kind? _____
Visual problems? YES / NO
Been in counseling? YES / NO
Eating disorder? YES / NO
Bulimia? YES / NO
Anorexia Nervosa? YES / NO

ALLERGIES

Allergies to Medicine?	What was the reaction?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Food?	What was the reaction?
_____	_____
_____	_____
_____	_____

Have you ever had reaction to anesthesia or has a family member had a reaction? YES / NO
Are you allergic to Latex products? YES / NO

PAST SURGICAL HISTORY

We need a complete list of all your previous surgeries. Please list the type of surgery below:

Tonsillectomy:	YEAR _____
Cholecystectomy (gallbladder removal):	YEAR _____
Appendectomy:	YEAR _____
Hysterectomy (removal of uterus):	YEAR _____
Cesarean Section (C-section):	YEAR _____
Oophorectomy (removal of ovary):	YEAR _____
Hiatal Hernia surgery:	YEAR_____
Cardiac Surgery	YEAR _____

Other Surgeries: PLEASE LIST: _____

SOCIAL HISTORY

Do you smoke? YES / NO
If yes, what kind? _____ How often? _____
What year did you start? _____ When did you quit? _____

How much alcohol do you drink per week?
Mixed drinks; _____ Beer; _____ Wine; _____

Have you ever used street drugs? YES / NO, if yes, what kind? _____
When was the last time you used? _____

EDUCATION:
What is your highest level of education?
Some High School High School / EGD College Post-Graduate

SUPPORT:
Does your family support your efforts to lose weight? YES / NO
Does your spouse / significant other supports your efforts to lose weight? YES / NO

Are they overweight or obese? YES / NO
Do your children support your efforts to lose weight? YES / NO
Are they overweight or obese? YES / NO

Describe your work and home life (family members, etc)
_____
_____
_____
_____

Name a close, supportive friend or family member who I can talk to: _____

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

	Mother	Father	Sibling	Aunt/Uncle	Grandparent
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Cancer					
Arthritis					
Death					

Cause of death of any family member: _____
_____

Has any member of your family suffered from Blood Clots or Pulmonary Embolism? YES / NO
If yes, please describe: _____

FOR WOMEN ONLY

Any pain with period? YES / NO
Have you ever been diagnosed with polycystic ovarian syndrome? YES / NO
Have you had problems conceiving? YES / NO
How many pregnancies have you had? YES / NO
How many children do you have? _____

MEDICATIONS (Report **name, dose, and frequency** and what you are taking it for)

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION