BHS Bariatrics

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BARIATRIC SURGERY HEALTH HISTORY

PATIENT INFORMATIION (*please print*)

NAME: _____

ADDRESS: _____

_____

PHONE: _____

CELL: _____

ALTERNATE PHONE: _____

E-MAIL: _____

DATE OF BIRTH: _____

OCCUPATION: _____

Full Time Part Time

MARITAL STATUS: _____

SOCIAL SECURITY #:_____

DRIVER'S LICENSE #_____

EMPLOYER: _____

BUSINESS ADDRESS: _____

_____

BUSINESS PHONE: _____

INSURANCE: _____

ID: _____

SPOUSE OR PARENT INFORMATION

NAME: _____

ADDRESS: _____

_____

PHONE: _____

PHARMACY: _____

PHARMACY PHONE: _____

PRIMARY PHYSICIAN: _____

PHYSICIAN PHONE: _____

CARDIOLOGIST: _____

PULMONOLOGIST: _____

HOW DID YOU HEAR ABOUT US?

□ INTERNET □ FRIEND

□ NEWSPAPER □ OTHER

□ FAMILY DOCTOR _____

EMERGENCY CONTACT (relative, friend, or neighbor)

NAME: _____

ADDRESS: _____

_____

PHONE: _____

RELATIONSHIP: _____

COMMERCIAL INSURANCE:

I hereby authorize payment of benefits directly to the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination and treatment to permit processing of claims for insurance reimbursement. A photocopy of this signature is valid as the original.

Signature of Patient or Representative: _____ Date: _____

Please have insurance cards available for copying. We will be happy to assist you with your insurance billing. Although an insurance claim is filed, the patient is responsible for the account with us.

Health History reviewed for changes: _____ Date: _____

MEDICATIONS *(list all current medications that you are taking)*

____ I do not take any medications.

NAME	Why taking	Dose	Date Started

**** If more, put other medicines on back of form****

Do you take a Multi-Vitamin: Yes No

ALLERGIES:

____ No known drug allergies ___ Seasonal ___ Tapes

Medication	Date	Reaction	Comments

SOCIAL HISTORY:

Do you smoke	Yes	No	How many packs per day _____
Do you chew tobacco/snuff	Yes	No	How long have you smoked_____
Do you use illicit drugs	Yes	No	
Do you drink alcohol	Yes	No	How many drinks per week_____
Do you drink caffeine	Yes	No	How many cups per day_____
Have you ever been treated for substance abuse	Yes	No	(Coffee, Tea, Pop)
Do you wear glasses/contacts	Yes	No	When was you last eye exam_____
Do you wear dentures	Yes	No	When was your last dental exam_____
Do you wear seatbelts	Yes	No	
Do you exercise regularly	Yes	No	
Do you use or belong to a health club	Yes	No	
Do you live in an unsafe environment or have any Fears for your physical safety	Yes	No	

Patient Name: _____ D.O.B._____

Have you had previous weight loss surgery? Yes No
If so: Where: _____ Date: _____ Surgeon: _____
Pre-op Weight: _____ Total Weight Loss: _____

DIET HISTORY: In the last 5 years:

_____ Lowest wt. _____ Highest wt. _____ Current wt.
_____ Sweet eater _____ Binge eater _____ Grazer
_____ Boredom _____Emotional eater

EATING DISORDER:

_____Bulimia _____Anorexia if so, how long ago _____ Were you treated: Yes No

DIETS YOU HAVE TRIED IN THE PAST:

☐ Atkins ☐ South Beach ☐ Weight Watchers ☐ Weight loss medications other: _____
How many meals do you eat in a day: _____
How long have you considered weight loss surgery? _____

FAMILY HISTORY:

		Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Other	Degenerative Joint Disease	Stroke	Other
Mother									
Father									
Siblings									
Grandparents									
Others									

PREVIOUS SURGERIES:

Procedure	Date	Procedure	Date

Patient Name: _____ D.O.B._____

Systems Review [In general, any problems with any of the following—please check]:

General:

□ Dizziness □ Fainting Spells □ Frequent Headaches □ Weight Loss □ Weight Gain
□ Fatigue □ Fever □ Anorexia

Head/Neck/Ear/Nose/Throat/Eye:

□ Blurred/Double Vision □ Glaucoma □ Mouth problems □ Sinus problems
□ Cataracts □ Hearing problems □ Nose bleeds □ Swollen glands
□ Earaches □ Hoarseness □ Ringing in ears □ Visual problems
□ Photophobia □ Dysphagia □ Eat Discharge

Heart:

□ Chest Pain □ Heart failure □ Palpitations □ Syncope
□ Chest pain with exertion □ Heart murmur □ Rheumatic fever □ PND

Lungs/Respiratory:

□ Asthma □ Frequent cold □ Need pillows to breathe w/sleep
□ Breathing problems w/exertion □ Frequent cough □ Shortness of breath
□ Breathing problems w/sleep □ Lung disease □ Tuberculosis [TB]
□ Sleep Apnea □ Wheezing □ Excessive Sputum

Intestinal:

□ Abdominal pains □ Change in bowel habits □ Heartburn □ Trouble swallowing
□ Appetite problems □ Constipation □ Hemorrhoids □ Ulcers
□ Black tarry stools □ Diarrhea □ Hepatitis □ Vomit blood
□ Blood in stools □ Irritable Colon □ Rectal pain □ Yellow skin
□ Food sticking in chest □ Colitis □ Acid Stomach

Urinary:

□ Blood in urine □ Kidney stones □ Pain/burning
□ Frequent urination □ Loss of control of urine □ Sexually transmitted disease
□ Infections □ Nighttime urinations □ Urgency

Females:

How many times have you been pregnant? _____ How many births have you had?_____
First day of your last menstrual period: _____ Last mammogram, if done: _____
Do you examine your breasts monthly? Yes No Any history of abnormal pap smears? Yes No
Last PAP? _____ Last transvaginal if done: _____
Any problems with:

□ Irregular bleeding □ Pain with intercourse □ Vaginal discharge
□ Missed periods □ Pain with period □ Vaginal/pelvic pain

Males:

Do you examine your testicles monthly? Yes No Decrease in sexual desire? Yes No
Any problems with:

□ Change in stream □ Penile discharge □ Trouble achieving/maintaining erection
□ Night problems □ Testicular pain/mass

Skeletal:

□ Arthritis/joint pain □ Difficulty walking □ Numbness/tingling □ Muscle Weakness
□ Back pain □ Muscle cramps □ Stiffness

Skin: □ Changing/Irregular Moles □ Rash □ Itching □ Dryness □ Lesions □ Other

Neurological:

□ Syncope □ Speech problems □ Vertigo □ Pins & Needles Feeling
□ Seizures □ Strokes □ Weakness □ Dizziness

Psychological: □ Anxiety □ Depression □ Paranoia □ Suicide Thoughts □ Hallucinations

Endocrine: □ Chills □ Sweats □ DM □ Excessive Thirst □ Excessive Hunger □ Polyuria

Heme: □ Abnormal bruising □ Bleeding □ Swollen Lymph Nodes

List any other concerns you may have: _____