BARIATRIC HEALTH HISTORY FORM

FIRST NAME:____________________________ **MI:**_______ **LAST NAME:** ____

DOB: __________________ **AGE:** _______

Personal Physician(s);

Family Medicine:_______________________________________ Internist:____

Referring Provider:____

Pulmonary:____ Endocrine:____

Cardiologist:____ Other:____

Current Medications:

Name	Dose	Frequency

ALLERGIES:

Medications/Other	Type of Reaction

Medical History:

Name of Condition	Estimated Date of Diagnosis	Complications

Medical History Continued:

Name of Condition	Estimated Date of Diagnosis	Complications

Surgical History:

Surgery	Estimated Date	Complications

Family History: (Please answer these questions about your grandparents, parents, brothers & sisters (not yourself)

Condition	Which Family Member?	Which Type Specifically?
Obesity		
Heart Disease		
Diabetes		
High Blood Pressure		
Lung Problems		
Bleeding Disorder		
Gallstones		
Cancer		

Social History:

Marital Status: ___________________________ Children: _______________________________

Employment Status: Full time:_______ Part time:_______Self Employed____________ List occupation:__________________________________

Unemployed_____Homemaker_____Retired__________Student ________Disabled ________If disabled, reason:________________________

Current Smoker___________If yes, #PPD_____________________Occasional Smoker_______________If yes, how often__________________

Former Smoker ___________ Quit Date________________ Never Smoked __________ Exposure to Passive Smoke_______________________

Chewing Tobacco Use _____If yes, amt/day____________ Former Chewing Tobacco Use ______________If yes, quit date___________________

Electronic cigarettes ______ if yes, amt/day ____________

Alcohol Use_____________________Type, Amount, Frequency____

Marijuana use ____________________ Type, Amount, Frequency ____

Drug Use________________________ Type, Amount, Frequency____

Caffeine Use _____________If yes, how much per day___________________________Regular Exercise Yes No

Religion Affecting Care____ HIV/High Risk Behavior___________________

OTHER:

How long have you been considering weight loss surgery? ____

What type of research have you done? ____

What is your motivation for weight loss surgery? ____

Are you committed to making life-long eating and behavior changes? Yes No

Are you committed to at least five years of follow-up with our program? Yes No

Have you been diagnosed with sleep apnea? Yes No

If yes, are you using CPAP or Bi-PAP? Yes No

If yes, do you use your machine every night? Yes No

***If you have NOT been diagnosed and/or treated for sleep apnea, please answer the questions on the next page.**

STOP –BANG QUESTIONNAIRE

☐ Y ☐ N **SNORING?**
Do you snore loud enough to be heard through closed doors or your bed partner elbows you for snoring at night?

☐ Y ☐ N **TIRED?**
Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving)?

☐ Y ☐ N **OBSERVED?**
Has anyone observed that you stopped breathing and/or was choking/gasping during your sleep?

☐ Y ☐ N **PRESSURE?**
Do you have or are being treated for high blood pressure?

☐ Y ☐ N **BODY MASS INDEX MORE THAN 35?**

☐ Y ☐ N **AGE OLDER THAN 50?**

☐ Y ☐ N **NECK SIZE LARGE?**
Measured around the Adam's apple.
For male, is your shirt collar 17 inches / 43 cm or larger?
For female, is your shirt collar 16 inches / 41 cm or larger?

☐ Y ☐ N **GENDER = MALE?**

DIET HISTORY

Please include approximate date of weight loss, pounds lost & pounds gained. This is VITAL information to our program and to YOUR insurance company.

CIRCLE the diet you have tried and fill in any diet that is NOT listed.

Please be most specific regarding weight loss attempts over the last two years.

NAME OF DIET	YEAR DIET ATTEMPT	NUMBER OF POUNDS LOST	NUMBER OF POUNDS GAINED
Alli			
Atkins			
Cabbage Soup			
Calorie Counting			
Carb Counting			
Cleveland Clinic Diet			
Dexatrim			
Dietitian Supervised			
Diet Center			
Fen-Phen			
Grapefruit			
Gym Membership			
Herbal Life			
Hypnosis			
Jenny Craig			
Isagenix			
LA Weight Loss			
Master Cleanse			
Medifast			
Meridia			
Metabolife			
Mayo Clinic Diet			
Nutri-Systems			
Optifast			
Overeaters Anonymous			
Personal Trainer			
Portion Control			
PRISM			
Pritiken Diet			
Protein Powder			
Richard Simmons			
Scarsdale Diet			
Slim Fast			
Slim Quick			
South Beach			
Subway Diet			
Sugar Busters			
TOPS			
Weight Loss Center			
Weight Watchers			
Xenical			
The Zone			

Surgeon Signature: ____ Date: ____________________

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