Bariatric Clinic – New Patient Form (complete prior to your appointment. Thanks)

HEALTH HISTORY QUESTIONNAIRE

The following information is very important to our ability to care for you. Please take time to fully and completely fill out this information. We are counting on you to provide us with accurate health history information.

Name:	Age:	DOB:
Medicine Allergies:		

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS

Vitamin or Supplement	Dose	Vitamin or Supplement	Dose
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

PAST MEDICAL HISTORY

Past or current medical history. Please check all that apply.

□ High Blood Pressure	□ Heart Failure □ Heart Attack □ Heart Disease	□ Arthritis □ Back pain □ Knee pain	□ Sleep Apnea □ Use CPAP
□ Diabetes	□ Elevated Cholesterol	□ Cancer	□ Hepatitis/liver disease
□ Stroke	□ COPD or Emphysema	□ Kidney Failure	□ GERD/Heartburn
□ Blood Clots	□ Atrial Fibrillation □ Other heart arrhythmia	□ Vascular Disease	□ Hypothyroidism □ Hyperthyroidism
□ Asthma	□ Depression □ Anxiety	□ Hormone therapy	□ Chronic Steroid Therapy
□ Glaucoma	□ Polycystic Ovarian Syndrome		
Have you ever had a colonoscopy? If yes, when?			
Please list any other medical conditions:			

PAST HOSPITALIZATIONS (OTHER THAN SURGERY)

Year	Reason
1.	
2.	
3.	

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PAST SURGICAL HISTORY

Surgical History and Type:	Date of Surgery:
□ None	
□ Chest Surgery	
□ Abdominal Surgery	
□ Hernia Repair	
□ Breast Surgery	
□ Heart Surgery	
□ Hysterectomy	
□ Other (please list)	

FAMILY HISTORY

Family History:	Family Relationship:
□ Colon Cancer	
□ Breast Cancer	
□ High Blood Pressure	
□ Diabetes	
□ Heart Attack (at what ages?)	
□ Stroke	
□ Aneurysms	
□ Overweight/obesity	

SOCIAL HISTORY

Occupation:	
Marital Status:	□ Married □ Single □ Widowed □ Divorced □ Partnered
Tobacco use:	□ Never □ Previously, but quit □ Currently (___pks/day ; ___ yrs smoker)
Alcohol:	□ Never □ Rarely □ Weekly □ Daily
□ Ever treated for alcohol or other substance abuse or dependency? When?	
□ Age first aware of weight issues?_____ Maximum lifetime weight?_____	
□ What do you like to do for exercise?	
□ How many days/week do you exercise?_____ For how long each time?_____ mins	

For staff use
C: □ yes □no
A: □ yes □no
G: □ yes □no
E: □ yes □no

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REVIEW OF SYSTEMS

Check the boxes that apply to YOU.	
Constitutional:	□ Weight gain □ Weight Loss
Eyes:	□ Double vision □ Blurred vision
Cardiovascular:	□ Chest pain □ Leg pain □ Dizziness □ Fainting spells
ENT:	□ Hearing loss □ Sore throat
Respiratory	□ Excessive shortness of breath □ Chronic/Persistent cough
Gastrointestinal:	□ Recent blood in stool □ Heart Burn □ Diarrhea □ Constipation
Genitourinary:	□ Difficulty with urination □ Incontinence
Musculoskeletal:	□ Leg cramps □ Joint pain
Skin:	□ Excessive dryness, scaling □ Skin tags
Breast:	□ Breast mass □ Nipple discharge
Neurological:	□ Seizures □ Tremor □ Headaches
Psychiatric:	□ Depression □ Bipolar disorder □ Anxiety
Endocrine:	□ Hot/Cold episodes
Hematology/Lymphatic:	□ Abnormal bleeding
Allergy/Immunology:	□ Problems with anesthesia □ Latex or tape allergy □ Food/gluten allergy

Please list any other symptoms or problems you are having here:

_____

_____

_____

_____

_____

PAST DIETS

Diet	Problems or Success?
1.	
2.	
3.	
4.	

PAST DIET MEDICATIONS

Medication	Side Effects, Problems or Success?
1.	
2.	
3.	

The above is true and correct to the best of my knowledge. (Please sign below)

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Signature _____ Date _____