BARIATRIC SERVICES
HEALTH HISTORY PROFILE

LAP-BAND ☐ GASTRIC BYPASS ☐ GASTRIC SLEEVE☐ OTHER☐

FIRST NAME:_____ INITIAL:_____ LAST NAME:_____

DATE OF BIRTH:_____ REFERRING DOCTOR:_____

CELL#:_____ E-MAIL:_____ REASON

FOR VISIT:_____

_____

EMERGENCY CONTACT PERSONS:

NAME/RELATION:_____ PHONE#:_____

ADDRESS:_____

CURRENT MEDICATIONS:
LIST ALL MEDICATIONS YOU ARE CURRENTLY ON WITH CORRECT SPELLING:

Medication	Dosage	Instructions (# per day)	Reason for taking medication

MEDICAL HISTORY:
HAVE YOU EVER SUFFERED WITHI ANY OF THE FOLLOWING HEALTH PROBLEMS (√ only ones apply)

HEALTH PROBLEMS	YES	HEALTH PROBLEMS	YES
ANEMIA OR BLEEDING DISORDER		HIGH BLOOD PRESSURE	
ANXIETY		HIGH CHOLESTEROL	
ARTHRITRIS OR JOINT PAIN		HERNIA (Type)	
ASTHMA		JOINT DISEASE/OSTEOPOROSIS	
BACK PAIN		KIDNEY OR URINARY DISORDER	
CANCER (TYPE)		NEUROLOGICAL DISORDER	
CHRONIC FATIGUE SYNDROME		PARATHYROID	
DEPRESSION		NERVOUS DISORDER	

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HEALTH PROBLEMS	YES	HEALTH PROBLEMS	YES
DIABETES		REFLUX/HEARTBURN	
ECZEMA OR SKIN CONDITION		RESPIRATORY/BREATHING (SOB)	
FIBROMYALGIA OR LUPUS		SLEEP APNEA	
GALLSTONES		THYROID (HYPER OR HYPO)	
GASTRIC OR DUODENAL ULCER		VARICOSE VEINS OR LEG SWELLING	
HEART DISEASE (CHF, STROKE, etc.)		VISION PROBLEMS/MIGRAINES	
BLOOD CLOT/PULMONARY EMBOLUS/DEEP VEIN THROMBOSIS			

ALLERGIES: LATEX ALLERGY: ☐ Yes ☐No

(INCLUDES MEDICATIONS, FOODS, DRESSINGS)

_____ REACTION:_____

_____ REACTION:_____

_____ REACTION:_____

SURGICAL HISTORY/HOSPITALIZATIONS:
PLEASE GIVE DETAILS OF ANY PAST OPERATIONS (WHAT TYPE, AGE, COMPLICATIONS)

TYPE OF SURGERY	DATE

FAMILY MEDICAL HISTORY

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LIST ALL MEDICATIONS YOU ARE CURRENTLY ON WITH CORRECT SPELLING:

PELASE (√) ALL THAT APPLY	FATHER	DAUGHTER	SON	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	SISTER	BROTHER
ASTHMA										
ANEMIA OR BLEEDING DISORDER										
CANCER (TYPE)										
DIABETES										
FIBROMYALGIA OR LUPUS										
GALLSTONES										
HEART DISEASE (CHF, STROKE, etc.)										
HERNIA (Type)										
HIGH CHOLESTEROL										
HIGH BLOOD PRESSURE										
OBESITY										
OSTEOPOROSIS										
REFLUX										
SNORING/SLEEP APNEA										
THYROID DISEASE										
VARICOSE VEINS										
OTHER:										

PULMONARY	**YES**	**NO**
Have you ever smoked? PPD x years If **YES**, you will need to **STOP SMOKING** two weeks prior to surgery.		
How often do you smoke cigarettes? Every Day☐ Some Days ☐		
How many cigarettes a day do you smoke? 5 or less☐ 6-10☐ 11-20☐ 21-30☐ More than 30☐		
Do you smoke your first cigarettes? Within 5 mins. ☐ 6-30 mins. ☐ 31-60 mins. ☐ After 1 hr.☐		
Are you interested in quitting? Ready to Quit ☐ Think About Quitting☐ Not Ready☐		
Do you have Asthma?		
Do you have chronic bronchitis?		
Do you have emphysema?		
Date of last Flu Vaccine_____ Last Pneumonia Vaccine_____		
Have you had pneumonia in the past 30 days?		
Do you use oxygen at home?		
If yes, do you use a CPAP/BiPAP machine?		
Do you have problems with your immune system?		
Do you have religious or other objections to blood transfusion?		
Cultural/Religions Requests		
CARDIAC	**YES**	**NO**

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How long have you had high blood pressure?: _____ years	☐	☐
Are you on a diuretic (water pill)?	☐	☐
Do you have chest pain at rest?	☐	☐
Do you have chest pain when exercising?	☐	☐
Have you ever had a heart attack? How many?:_____ Date(s)_____ Last Cardiologist Visit_____	☐	☐
Have you ever had Congestive Heart Failure? Date: _____	☐	☐
Do you have a heart stent? Date:_____	☐	☐
Do you have an irregular heart beat or heart rhythm?	☐	☐
Do you have a heart murmur or mitral valve prolapse?	☐	☐
Have you ever had a heart valve replacement? Date:_____ Which Valve?_____	☐	☐
Do you have a Pacemaker or Defibrillator?	☐	☐
Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	☐	☐
Are you on cholesterol medication?	☐	☐
Have you ever been told you have peripheral vascular disease?	☐	☐
Have you ever had an EKG test? Test Location:_____ Date:_____	☐	☐
Have you ever had a stress test? Test Location:_____ Date:_____	☐	☐
Have you ever had an cardiac echo test? Test Location:_____ Date:_____	☐	☐
Have you ever had an heart catherization test? Test Location:_____ Date:_____	☐	☐
ENDOCRINE/NEURO	**YES**	**NO**
Do you have diabetes?_____ Year Diagnosed?_____	☐	☐
Do you use Insulin?	☐	☐
Do you have thyroid problems?	☐	☐
Have you ever had a stroke? Date:_____	☐	☐
Have you ever had a seizure?	☐	☐
Are you on medication for seizures?	☐	☐
Date of last eye exam?_____	☐	☐
GENERAL	**YES**	**NO**
Any Implants/Location	☐	☐
Do you have kidney/renal problems?	☐	☐
Are you on dialysis? What days for dialysis? M☐ T ☐ W☐ TH☐ F☐ SA☐ SU☐	☐	☐
Do you have liver problems?	☐	☐
Have you ever had Hepatitis A / B / C / D? Please list:	☐	☐
Do you use recreational drugs? Type:_____ HOW OFTEN:_____	☐	☐

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PSYCHOSOCIAL	**YES**	**NO**
Do you drink alcohol? Never ☐ Rarely ☐ Regularly ☐ How many glasses do you drink a day?_____ List type of alcohol you drink (wine, beer, liquor, etc.)_____	☐	☐
Do you use recreational drugs? Which one(s)?_____ How often? Never ☐ Rarely ☐ Daily ☐	☐	☐
Do you use Herbal Medications? Which ones?	☐	☐
Lives: ☐ At Home ☐ Nursing Home ☐ Alone ☐With Spouse ☐ With Family ☐ Other	☐	☐
Cultural/Religious Requests?	☐	☐
Childhood Immunizations: ☐ Yes ☐ No ☐ Unknown		
HEMO/ONC	**YES**	**NO**
Have you ever had a blood clot, pulmonary embolus or deep vein thrombosis?	☐	☐
Do you have bleeding tendencies?	☐	☐
Do you have sickle cell disease or trait?	☐	☐
Do you take any anticoagulants (blood thinners)?	☐	☐
Do you have a history of anemia?	☐	☐
Do you take Aspirin or analgesics regularly?	☐	☐
Do you have a history of cancer?	☐	☐
Are you on chemotherapy? Date of last chemotherapy:	☐	☐
Have you had radiation treatment? Date of last treatment:	☐	☐
PSYCHIATRIC	**YES**	**NO**
Are you currently seeing a therapist/counselor/psychiatrist? If so, how long?_____	☐	☐
Have you ever been hospitalized? Date:	☐	☐
Are you taking psychiatric medications? List: 1)_____ 2)_____ 3)_____ 4)_____	☐	☐
Have you ever been diagnosed with schizophrenia?	☐	☐
Have you ever been diagnosed with bipolar disorder?	☐	☐

MUSCULOSKELETAL	**YES**	**NO**

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Swelling in legs or feet?		
Do you have Lupus?		
Do you have Scleroderma?		
Do you have joint pain? Where: Back ☐ Knees ☐ Ankles ☐ Feet ☐		
Does joint pain limit ability to walk or exercise?		
Do you exercise?		
What keeps you from exercising? Fatigue ☐ Lack of Time ☐ No Motivation ☐		
Are you willing to change your exercise habits?		
Date of last Flu Vaccine:_____ Last Pneumonia Vaccine:_____		
Have you been screened for osteoarthritis? If so, what year?:_____		
Do you use oxygen at home?		
If yes, do you use a CPAP/BiPAP machine?		
Do you have problems with your immune system?		
Do you have religious or other objections to blood transfusions?		
GASTROINTESTINAL	**YES**	**NO**
Do you have a history of Reflux or Heartburn? Many times per day ☐ most nights ☐ most weeks ☐		
What causes your reflux or heartburn? Eating late☐ Spicy foods ☐ Other ☐		
Do you have difficulty? Swallowing ☐ Food getting stuck ☐ Hoarseness ☐ Recurrent sore throat ☐ Frequent nausea ☐ Frequent vomiting ☐		
Do you have a regular cough at night?		
Do you have peptic ulcer disease?		
Do you have? Chronic abdominal pain ☐ Chronic diarrhea ☐ Chronic constipation ☐		
Do you have any of these hernias? Hiatal ☐ Inguinal ☐ Umbilical ☐ Ventral ☐		
MALE N/A ☐	**YES**	**NO**
Do you have urinary incontinence?		
Have you been diagnosed with any? Loss of erection ☐ Prostate Cancer ☐ Enlarged Breast ☐		
Date of last prostate exam?_____		
FEMALE N/A ☐	**YES**	**NO**
Do you have urinary incontinence?		
Do you suffer from excess body hair or acne?		
Do you have problems with infertility?		
Do you have polycystic ovaries?		
Date of last mammogram?		

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WEIGHT LOSS HISTORY

ATTEMPTS	DURATIOND DATES (How Long Did You Diet?)	WAS IT MEDICALLY SUPERVISED?	WEIGHT LOSS/GAIN
Weight Watchers/Atkins		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Jenny Craig/Nutrisystem/Gloria Marshall		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Hypnotherapy		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Liquid/Grapefruit		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Phentermine (Apidex, Fastin, Pondimen)		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Slimfast/Optifast		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
TOPS		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.
Other (Please write below)		YES ☐ NO☐	☐ Loss _____ lbs. ☐Gain _____ lbs.

VITMANS/SUPPLEMENTS/HERBS:

Do you take multivitamins or other dietary supplements? Yes ☐ No ☐ How Often? _____

List the vitamins or herbal supplements you take: _____

_____

ADDITIONAL PHYSICIANS (IF APPLICABLE):

CARDIOLOGIST: _____ Telephone Number: _____

ENDOCRINOLOGIST: _____ Telephone Number: _____

ENT (EAR/NOSE/THROAT): _____ Telephone Number: _____

GASTROENTEROLOGIST: _____ Telephone Number: _____

GYNECOLOGIST: _____ Telephone Number: _____

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ADDITIONAL PHYSICIANS (IF APPLICABLE):

INTERNAL MEDICINE: _____ Telephone Number: _____

NEUROLOGIST: _____ Telephone Number: _____

NEPHROLOGIST: _____ Telephone Number: _____

ONCOLOGIST: _____ Telephone Number: _____

ORTHOPEDIC: _____ Telephone Number: _____

PRIMARY CARE (PCP): _____ Telephone Number: _____

PSYCHIATRIST: _____ Telephone Number: _____

OTHER: _____ Telephone Number: _____

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PHARMACIES (LIST ALL YOU USE)

NAME: _____ PHONE(S) _____

NAME: _____ PHONE(S) _____

I have been informed of immediate risk and life-long effects after surgery for:

☐Lap-band ☐Gastric Bypass ☐ Gastric Sleeve ☐Hiatal Hernia

☐Other:

_____

Did you understand? Yes ☐ No ☐

PATIENT STATEMENT:

TO THE BEST OF MY KNOWLEDGE THE INFORMATIION ON PREVIOUS PAGES ARE ACCURATE AND COMPLETE.

SIGNED: _____ DATE: _____

PHYSICIAN STATEMENT:

I HAVE REVIEWED THE QUESTIONAIRE.

COMMENTS:

_____

_____

_____

_____

☐This patient is a good Bariatric Surgical Candidate

☐This patient is not a good Bariatric Surgical Candidate

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____