LONG ISLAND BARIATRIC, PLLC

Wellness & Weight Management Center

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MEDICAL HISTORY FOR BARIATRIC PATIENTS

NAME: ________________________ DATE: ___________________

AGE: ______ HEIGHT: __________ WEIGHT: _________________

OCCUPATION: ____

MARITAL STATUS: ___MARRIED ___DIVORCED ___SINGLE ___PARTNERSHIP

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE: ___________________

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____________________________

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

HEADACHES	YES___NO___	STRESS INCONTINENCE	YES___NO___
SHORTNESS OF BREATH	YES___NO___	INDIGESTION/HEARTBURN	YES___NO___
COUGH	YES___NO___	VOMITING	YES___NO___
PALPITATIONS	YES___NO___	ABDOMINAL PAIN	YES___NO___
CHEST PAIN	YES___NO___	BLOOD IN URINE/STOOL	YES___NO___
DIZZINESS	YES___NO___	DIFFICULTY URINATING	YES___NO___
FATIGUE	YES___NO___	PAIN/SWELLING IN LEGS	YES___NO___
CONSTIPATION	YES___NO___	VARICOSE VEINS	YES___NO___
JOINT/MUSCLE PAINS	YES___NO___	DEPRESSION	YES___NO___
ANXIETY	YES___NO___	INSOMNIA	YES___NO___
SNORING	YES___NO___	EXCESSIVE DAYTIME SLEEPINESS	YES___NO___
IMPOTENCE	YES___NO___	FALL ASLEEP INAPPROPRIATELY	YES___NO___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING ILLNESSES/DISEASES?

HEART DISEASE	YES___NO___	DIABETES	YES___NO___
HIGH BLOOD PRESSURE	YES___NO___	HEART ATTACK	YES___NO___
STROKE	YES___NO___	HIGH CHOLESTEROL	YES___NO___
ASTHMA	YES___NO___	EMPHYSEMA/COPD	YES___NO___
DEPRESSION	YES___NO___	CONGESTIVE HEART FAILURE	YES___NO___
ARTHRITIS	YES___NO___	CANCER	YES___NO___
KIDNEY DISEASE	YES___NO___	GLAUCOMA/EYE PROBLEMS	YES___NO___
SLEEP APNEA	YES___NO___	GALLBLADDER DISEASE	YES___NO___

GASTRO ESOPHAGEAL REFLUX DISEASE (GERD)	YES___NO___	
POLY CYSTIC OVARIAN SYNDROME (PCOS)	YES___NO___	
LUPUS/OTHER COLLAGEN DISEASE	YES___NO___	
ULCER/GASTROINTESTINAL DISEASE	YES___NO___	
THYROID DISEASE	YES___NO___	HYPER OR HYPO *(PLEASE CIRCLE ONE)*

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES? YES___ NO___ ____#OF CIGARETTES/DAY

IF NO, HAVE YOU EVER SMOKED CIGARETTES IN THE PAST?

YES_____NO_______ __________# OF CIGARETTES/DAY DATE QUIT_________

DO YOU DRINK ALCOHOL? _____NO ____SOCIAL ____OCCASIONAL ____DAILY

DO YOU HAVE ANY HISTORY OF DRUG OR ALCOHOL ABUSE? YES___NO___

IF YES, PLEASE LIST: ____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ❑ NO ❑ YES IF YES, PLEASE LIST OR PROVIDE LIST (INCLUDE OVER THE COUNTER PREPARATIONS SUCH AS LAXATIVES, VITAMINS AND PAIN RELIEVERS):

MEDICATION	DAILY DOSE	FREQUENCY

* PLEASE INFORM RECEPTIONIST IF ADDITIONAL SPACE IS NEEDED

ARE YOU ALLERGIC TO ANY MEDICATIONS/FOOD? ❑ NO ❑ YES IF YES, PLEASE LIST:

____

____

PLEASE LIST ANY SURGERY OR HOSPITALIZATIONS, BEGINNING WITH THE MOST RECENT:

____

____

____

____

____

FOR OUR FEMALE PATIENTS:

NUMBER OF PREGNANCIES _________ NUMBER OF CHILDREN ____________________

ARE YOUR MENSTRUAL PERIODS REGULAR? YES___ NO_____ AGE OF MENOPAUSE ______________

DATE OF LAST PAP _____________________ DATE OF LAST MAMMOGRAPHY ___________________

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER	_______	___________________	_______	_______________________
MOTHER	_______	___________________	_______	_______________________
BROTHER(S)	_______	___________________	_______	_______________________
SISTER(S)	_______	___________________	_______	_______________________

DO ANY BLOOD RELATIVES HAVE / HAD:

	NO	YES	IF YES, WHO?
CANCER	❑	❑	____
TUBERCULOSIS	❑	❑	____
DIABETES	❑	❑	____
HEART DISEASE	❑	❑	____
HIGH BLOOD PRESSURE	❑	❑	____
STROKE	❑	❑	____
BREAST MASSES OR BREAST TUMORS	❑	❑	____

WHAT WOULD YOU SAY YOUR IDEAL WEIGHT IS? _______________

HOW LONG HAVE YOU BEEN OVERWEIGHT? _____________________

LIST REASONS WHY YOU WANT WEIGHT LOSS SURGERY

____

____

____

LIST ALL DIETS YOU HAVE TRIED INCLUDING DIET PILLS

____

____

____

____

LIST WEIGHT LOSS CLINICS ATTENDED

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____

____

LIST EXERCISE CLINICS ATTENDED

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____

LIST DOCTORS YOU HAVE SEEN FOR WEIGHT LOSS

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____

____

____

LIST INJECTIONS TRIED

____

____

____

____

LIST ACUPUNCTURE TRIED

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____

____

Sometimes things happen to people that are extremely upsetting, things like being in a life-threatening situation. We would like to ask if any of these kinds of things have happened to you at any time during your life. **Please place a "Yes" or "No" before each item**.

______ Have you ever been in a natural major disaster, like a hurricane, earthquake, or flood?

______ Have you ever been directly affected by a terrorist attack like 9/11?

______ Have you or anyone in your family been involved in or affected by a war?
If yes, please explain: ____

______ Have you ever been in a fire?

______ Have you ever been in a serious car accident?

______ Has there ever been a time when you've been seriously hurt or injured?

______ Have you ever been in the hospital or undergone treatment for any serious or life-threatening illness or injuries?

______ Have your parents or sibling(s) ever been in the hospital or undergone treatment for any serious or life-threatening problems?

______ Has anyone ever hit you or beaten you up (physically assaulted you)?
___ Has anyone ever threatened to do that?

______ Have you ever been hit or intentionally hurt by a family member?
___ Did you have bruises, marks or injuries?

______ Was there a time when adults who were supposed to be taking care of you didn't?

______ Have you ever lived with someone other than your parents while you were growing up?

______ Have you ever seen or heard someone in your family/house get threatened?

______ Have you ever seen or heard someone in your family/house get beaten up?

______ Have you ever seen or heard someone being beaten, or seen someone who was badly hurt?

______ Have you ever seen someone who was dead or dying, or watched or heard them being killed? _____ If yes, was this person a stranger, acquaintance, close friend, or family member? ____________________

______ Has anyone ever told you details of how someone you were close to was injured or killed?

______ Have you ever been threatened with a weapon?

______ Has anyone ever stalked you?

______ Did anyone ever try to kidnap you?

______ Has anyone ever made you do sexual things you didn't want to do, like touch you, make you touch them, or attempt to have any kind of sex with you?

______ Has anyone ever raped you?
___ IF NO: did anyone ever try?

______ Is there anything else really scary or very upsetting that has happened to you that we haven't asked you about? If yes, could you briefly describe it? ________________________
____

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SNORING – FATIGUE QUESTIONNAIRE

HOW WELL DO YOU SLEEP?

* Are you a loud and persistent snorer?	Yes____	No____
* Do you wake up tired and un-rested?	Yes____	No____
* Do you sometimes find it hard to stay awake during the day?	Yes____	No____
* Has your sleep mate ever said that you hold your breath or gasp for air while sleeping?	Yes____	No____

If you answered yes to any of the above then you may be at risk for sleep apnea. Please complete the next section which is based on the Epworth Sleepiness Scale which is standard gauge for determining if a sleep study is an appropriate step for your medical well being.

EPWORTH SLEEPINESS SCALE

Please answer the following on a scale of 0 to 3 with the thought in mind of your chances of dozing in each instance. **(0 = Never, 1 = Slight, 2 = Moderate, 3 = High)**

SITUATIONS	CHANCE OF DOZING
Watching TV	_______
Sitting and Reading	_______
Lying down in afternoon	_______
Sitting, talking to someone	_______
In car, while stopped for a few minutes	_______
Sitting quietly after lunch without alcohol	_______
Passenger in a car for an hour without a break	_______
Sitting inactive in a public place (movie, meeting, etc.)	_______
TOTAL SCORE	

Patient Name: ____

NAME: ____________________________ DATE: ____________

EATING QUESTIONNAIRE

1.	Do you think your eating habits are unusual?	**YES**	**NO**
2.	Do you eat when you are not hungry?	**YES**	**NO**
3.	Do you eat to escape from worries or troubles?	**YES**	**NO**
4.	Is your life dominated by thoughts of food?	**YES**	**NO**
5.	Is your eating out of your control?	**YES**	**NO**
6.	Do you feel guilt or remorse after overeating?	**YES**	**NO**
7.	Do you binge when you are alone?	**YES**	**NO**
8.	Do you resent being told to use your willpower to stop overeating?	**YES**	**NO**

IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE EXPLAIN ABOVE.