LONG ISLAND BARIATRIC, PLLC

General Surgery | Bariatric Surgery | Laparoscopic Surgery
Breast Surgery | Vascular/Ultrasound Lab | Pacemaker Clinic

Paayal P. Mehta, M.D., F.A.C.S

MEDICAL HISTORY

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: _____

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_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ❑ NO ❑ YES IF YES, PLEASE LIST OR PROVIDE LIST:

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:

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR SURGERY? IF YES, PLEASE LIST BEGINNING WITH THE MOST RECENT:

_____

_____

_____

_____

_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____

DO ANY OF YOUR BLOOD RELATIVES HAVE / HAD:

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

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? ❑ NO ❑ YES