Bariatric Innovations of Atlanta & General Surgery

First _____ **Middle**_____ **Last** _____ **DOB:** _____

PERSONAL MEDICAL HISTORY:

HAVE YOU EVER SUFFERED WITH ANY OF THE FOLLOWING HEALTH PROBLEMS:

HEALTH PROBLEMS (√)	**YES**	**ONSET OF PROBLEM?**	
ANEMIA OR BLEEDING DISORDER			
ANXIETY / DEPRESSION DISORDER			
ARTHRITIS OR JOINT PAIN			
ASTHMA			
BACK PAIN			
CANCER (TYPE)			
CHRONIC FATIGUE SYNDROME			
DIABETES (TYPE 1 OR TYPE 2)			
DIABETES WHILE PREGNANT			
ECZEMA OR SKIN CONDITION			
FIBROMYALGIA or LUPUS			
GALLSTONES			
GASTRIC OR DUODENAL ULCER			
HAYFEVER OR RHINITIS			
HEART DISEASE (CHF, STROKE, etc)			
HEPATIC OR LIVER DISEASE			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
INFERTILITY			
KIDNEY OR URINARY DISORDER			
NEUROLOGICAL DISORDER			
PCOS			
PSYCHOLOGICAL/NERVOUS DISORDER			
REFLUX / HEARTBURN			
RESPIRATORY/BREATHING (SOB)			
SLEEP APNEA			
THYROID (HYPER **OR** HYPO)			
VARICOSE VEINS OR LEG SWELLING			
VISION PROBLEMS/ MIGRAINES			
OTHER:			

ALLERGIES: None ☐ LATEX ALLERGY: Yes ☐ No ☐

(INCLUDE MEDICATIONS, FOODS, DRESSINGS)

_____REACTION _____

_____REACTION _____

_____REACTION _____

_____REACTION _____

_____REACTION _____

FAMILY MEDICAL HISTORY

PLEASE (√) ALL THAT APPLY	MOM	DAD	SON	DAUT	(M) GMOM	(P) GMOM	(M) GDAD	(P) GDAD	SIS	BRO	AUNT	UNCLE	DON'T KNOW
ALLERGIES													
ASTHMA													
CANCER (TYPE)													
DERMATITIS/ ECZEMA													
DIABETES													
GOUT													
GALLSTONES													
HAYFEVER													
HEART DISEASE (CHF, STROKE, etc)													
HIGH CHOLESTEROL													
HIGH BLOOD PRESSURE													
HIP FRACTURES													
OBESITY													
OSTEOPOROSIS													
PCOS, INFERTILITY													
SNORING / SLEEP APNEA													
THYROID DISEASE													
VARICOSE VEINS													
OTHER:													

MEDICATIONS:

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

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

VITAMINS/SUPPLEMENTS/HERBS:

DO YOU TAKE MULTIVITAMINS OR OTHER DIETARY SUPPLEMENTS? YES ☐ NO ☐ HOW OFTEN?_____

LIST THE VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE: _____

DO YOU TAKE FOLATE TABLETS: YES ☐ NO ☐ IF SO, HOW OFTEN?_____ DOSAGE: _____

WEIGHT LOSS HISTORY (FOR BARIATRIC CANDIDATES ONLY)

ATTEMPTS	DURATION DATES (HOW LONG DID 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 (ADIPEX, 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 in)		YES ☐ NO ☐	☐ LOSS _____ lbs ☐GAIN _____ lbs

AGE YOU BEGAN YOUR FIRST DIET?_____ HOW LONG HAVE YOU BEEN OVERWEIGHT? _____

MOST WEIGHT YOU EVER LOST? _____lbs HOW MANY MEALS YOU EAT A DAY? _____

HOW MANY SNACKS A DAY? _____ HOW OFTEN DO YOU EAT SWEETS? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING? ☐ LATE NIGHT SNACKING ☐ CONSTANTLY SNACKING

☐ EATING QUICKLY ☐ FREQUENTLY EATING FAST FOODS ☐ LARGE BITES ☐ LARGE PORTIONS

HOW OFTEN DO YOU EAT OUT? 1-5 MEALS/WEEK ☐ 6-10 MEALS/WEEK ☐ 10+ MEALS/WEEK ☐

SOCIAL

DO YOU CURRENTLY SMOKE? YES ☐ NO ☐ HOW MANY YEARS?_____

HAVE YOU EVER SMOKED? YES ☐ NO ☐ HOW MANY YEARS?_____

HOW MANY CIGARETTES PER DAY? _____

IF YES, YOU WILL NEED TO STOP SMOKING **TWO** WEEKS BEFORE SURGERY.

DO YOU DRINK ALCOHOL: NEVER ☐ FORMER ☐ HEAVY ☐ LIGHT ☐

HOW MANY GLASSES DO YOU DRINK A DAY? _____

HOW MANY DAYS DO YOU DRINK PER WEEK? _____

LIST THE TYPE OF ALCOHOL YOU DRINK (WINE, BEER, LIQUOR) _____

SURGICAL HISTORY:

PLEASE GIVE DETAILS OF ANY PAST OPERATIONS (WHAT TYPE, AGE, COMPLICATIONS)

TYPE OF SURGERY	DATE	SURGEON / PLACE

PHARMACIES (LIST ALL YOU USE)

NAME: _____ PHONES: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL	☐ weight gain ☐ weight loss ☐ fatigue ☐ fever ☐ chills
EYES	☐ loss of visual activity ☐ changes in vision ☐ blurred vision
HEENT	☐ recurrent pharyngitis ☐ recurrent tinnitus ☐ nasal airway ☐ obstruction ☐ hoarseness ☐ neck pain ☐ recent voice changes ☐ thyroid mass ☐ excessive snoring ☐ blurred vision ☐ difficulty swallowing
CARDIOVASCULAR	☐ hypertension ☐ dyspnea ☐ tachycardia ☐ hyperlipidemia ☐ atherosclerotic disease ☐ chest pain ☐ cardiac murmurs ☐ irregular heartbeats ☐ cardiac stents
RESPIRATORY	☐ shortness of breath ☐ pulmonary embolism ☐ dyspnea ☐ obstructive sleep apnea ☐ congestive obstructive pulmonary disease ☐ orthopnea ☐ sleep apnea ☐ exertional dyspnea ☐ CPAP
GASTROINTESTIONAL	☐ heartburn ☐ nausea/vomiting ☐ loss of appetite ☐ gastro esophageal reflux ☐ dysphagia ☐ constipation ☐ diarrhea ☐ abdominal pain ☐ change in abdominal girth
INTEGUMENT	☐ rash ☐ itching ☐ new skin lesions ☐ changes to existing skin condition
NEUROLOGIC	☐ tingling or numbness ☐ seizures ☐ muscular weakness
MUSCULOSKELETAL	☐ bone pain ☐ joint pain ☐ limitation of range of motion ☐ difficulty ambulating ☐ stiffness
ENDOCRINE	☐ weight gain ☐ weight loss ☐ diabetes ☐ obesity
PSYCHIATRIC	☐ depression ☐ anxiety ☐ insomnia ☐ suicidal ideations
HEME-LYMPH	☐ bleeds easily ☐ bruises easily ☐ lymph node enlargement

PATIENT STATEMENT:

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ON PREVIOUS PAGES IS ACCURATE AND COMPLETE.

SIGNED: _____ DATE: _____ TIME: _____

PHYSICIAN STATEMENT:

I HAVE REVIEWED THE QUESTIONNAIRE.

COMMENTS:

_____

_____

PHYSICIAN SIGNATURE: _____DATE: _____ TIME: _____

HEALTH HISTORY PROFILE