Bariatric Innovations
Bariatric & General Surgery
A Northside Network Provider

English - Spanish

AFFIX PATIENT LABEL HERE

First ______________________________ **Middle**______ **Last** ____________________________________ **DOB:** _____________

HOW DID YOU HEAR ABOUT US?

☐ DOCTOR ☐ PATIENT ☐ INTERNET SEARCH ☐ INSURANCE COMPANY ☐ OTHER

PRIMARY CARE PHYSICIAN

NAME: ____ PHONE: ________________________________

PHARMACIES (PLEASE LIST ALL YOU USE)

PHARMACY NAME: ____ PHONE: ________________________________

PHARMACY NAME: ____ PHONE: ________________________________

PERSONAL MEDICAL HISTORY:

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

HEALTH PROBLEMS	YES (√)	WHEN DID IT START/WAS DIAGNOSED	
ANEMIA OR BLEEDING DISORDER	☐		
ANXIETY / DEPRESSION	☐		
ARTHRITIS OR JOINT PAIN	☐		
ASTHMA	☐		
BACK PAIN	☐		
CANCER (TYPE)	☐		
CHRONIC FATIGUE SYNDROME	☐		
DIABETES (TYPE 1 OR TYPE 2)	☐		
PREDIABETES	☐		
DIABETES WHILE PREGNANT	☐		
ECZEMA OR SKIN CONDITION	☐		
FIBROMYALGIA, LUPUS, OTHER AUTOIMMUNE	☐		
GALLSTONES	☐		
GASTRIC OR DUODENAL ULCER	☐		
HAYFEVER OR RHINITIS	☐		
HEART DISEASE (HEART FAILURE, STROKE, ETC)	☐		
LIVER DISEASE	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
INFERTILITY	☐		
KIDNEY OR URINARY DISORDER	☐		
NEUROLOGICAL DISORDER	☐		
PCOS (POLYCYSTIC OVARIAN SYNDROME)	☐		
PSYCHOLOGICAL/NERVOUS DISORDER	☐		
REFLUX / HEARTBURN	☐		
RESPIRATORY/BREATHING (SOB)	☐		
SLEEP APNEA	☐		
THYROID DISORDER (HIGH OR LOW)	☐		
VARICOSE VEINS OR LEG SWELLING	☐		
VISION PROBLEMS/ MIGRAINES	☐		
OTHER:	☐		

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SURGICAL HISTORY:

PLEASE GIVE DETAILS OF ANY PAST OPERATIONS

TYPE OF SURGERY	DATE	SURGEON / PLACE / COMPLICATIONS

SOCIAL

DO YOU CURRENTLY SMOKE? ☐ YES ☐ NO HOW MANY YEARS? ________ # OF CIGARETTES / DAY? ________
HAVE YOU EVER SMOKED? ☐ YES ☐ NO HOW MANY YEARS? ________
DO YOU CURRENTLY VAPE? ☐ YES ☐ NO HOW MANY YEARS? ________
IF YES, YOU WILL NEED TO STOP SMOKING **THREE** MONTHS BEFORE SURGERY.

DO YOU DRINK ALCOHOL: ☐ NEVER ☐ NOT CURRENTLY ☐ MONTHLY ☐ WEEKLY ☐ DAILY
HOW MANY DRINKS DO YOU HAVE A DAY? ________________
HOW MANY DAYS DO YOU DRINK PER WEEK? _____________
LIST THE TYPE OF ALCOHOL YOU DRINK (WINE, BEER, LIQUOR) __________________________________

REVIEW OF SYSTEMS: (SELECT ALL THAT APPLY)

CONSTITUTIONAL	☐ weight gain ☐ weight loss ☐ fatigue ☐ fever ☐ chills
EYES	☐ loss of visual activity ☐ changes in vision ☐ blurred vision
EARS, NOSE & THROAT	☐ sore throat ☐ ringing in ears ☐ nasal airway obstruction ☐ hoarseness ☐ neck pain ☐ voice changes ☐ thyroid mass ☐ loud/excessive snoring ☐ blurred vision ☐ difficulty swallowing
CARDIOVASCULAR	☐ chest pain ☐ shortness of breath ☐ palpitations/fast heart rate
RESPIRATORY	☐ shortness of breath ☐ trouble breathing while lying down ☐ CPAP use
GASTROINTESTIONAL	☐ heartburn ☐ nausea/vomiting ☐ gastroesophageal/acid reflux ☐ abdominal pain ☐ loss of appetite ☐ constipation ☐ diarrhea ☐ change in abdominal girth
SKIN	☐ rash ☐ itching ☐ new skin changes/wounds ☐ changes to existing skin condition
NEUROLOGIC	☐ headache ☐ tingling or numbness ☐ seizures ☐ weakness
MUSCULOSKELETAL	☐ bone pain ☐ joint pain ☐ limited range of motion ☐ difficulty walking ☐ stiffness
ENDOCRINE	☐ weight gain ☐ weight loss ☐ excessive thirst ☐ change in appetite
PSYCHIATRIC	☐ depression ☐ anxiety ☐ insomnia ☐ suicidal thoughts/wanting to harm myself
HEME-LYMPH	☐ easy bleeding ☐ easy bruising ☐ lymph node enlargement

AFFIX PATIENT LABEL HERE

FAMILY MEDICAL HISTORY

PLEASE (√) ALL THAT APPLY	DAD	MOM	SON	DAUGHTER	GRANDFATHER (MOM's SIDE)	GRANDMOTHER (MOM's SIDE)	GRANDFATHER (DAD's SIDE)	GRANDMOTHER (DAD'S SIDE)	SISTER	BROTHER	AUNT	UNCLE	DON'T KNOW
ALLERGIES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER (TYPE)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DERMATITIS/ ECZEMA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GOUT	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GALLSTONES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HAYFEVER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE (HEART FAILURE, 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

ALLERGIES: ☐ None

LATEX ALLERGY: ☐ Yes ☐ No

(INCLUDE MEDICATIONS, FOODS, DRESSINGS)

_______________________________REACTION _______________________________

_______________________________REACTION _______________________________

_______________________________REACTION _______________________________

_______________________________REACTION _______________________________

_______________________________REACTION _______________________________

FOR THE FOLLOWING SECTIONS, PLEASE ANSWER QUESTIONS RELATED TO TODAY'S VISIT

1. WEIGHT LOSS PATIENTS (IF NOT HERE FOR WEIGHT LOSS SKIP TO #2)

ATTEMPTS	DURATION DATES (LENGTH OF DIET)	WAS IT MEDICALLY SUPERVISED?	WEIGHT LOSS / GAIN
WEIGHT WATCHERS/ ATKINS		☐ YES ☐ NO	☐ LOSS _____ lbs ☐ GAIN _____ lbs
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
WEIGHT LOSS INJECTIONS (BRAND OR COMPOUNDED)		☐ YES ☐ NO	☐ LOSS _____ lbs ☐ GAIN _____ lbs
SLIMFAST/ OPTIFAST		☐ YES ☐ NO	☐ LOSS _____ lbs ☐ GAIN _____ lbs
ATKINS / KETO		☐ YES ☐ NO	☐ LOSS _____ lbs ☐ GAIN _____ lbs
Hx of BARIATRIC SURGERY		☐ YES ☐ NO	Weight at time of surgery________ Lowest weight after surgery________
OTHER (Please write in)			

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

WHAT IS YOUR HIGHEST (NON-PREGNANT) WEIGHT? ____________lbs WHEN?______________________

WHAT IS YOUR LOWEST WEIGHT? ____________lbs WHEN?______________________

MOST WEIGHT YOU EVER LOST? ________lbs WHAT DID YOU DO? ______________________

HOW MANY MEALS DO YOU EAT A DAY? ____________

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

SELECT IF 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

DURING THE LAST 3 MONTHS, DID YOU HAVE ANY EPISODES OF EXCESSIVE OVEREATING (EATING SIGNIFICANTLY MORE THAN MOST PEOPLE WOULD EAT IN SAME PERIOD OF TIME)? ☐ YES ☐ NO

DO YOU FEEL STRESSED ABOUT YOUR EPISODES OF EXCESSIVE OVEREATING? ☐ YES ☐ NO

WITHIN THE PAST 3 MONTHS…	NEVER OR RARELY	SOMETIMES	OFTEN	ALWAYS
During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?	☐	☐	☐	☐
During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?	☐	☐	☐	☐
During your episodes of excessive overeating, how often were you embarrassed by how much you ate?	☐	☐	☐	☐
During your episodes of excessive overeating, how often did you feel upset or guilty afterward?	☐	☐	☐	☐
During the last 3 months, how often did you make yourself vomit as a means to control your weight?	☐	☐	☐	☐

2. REFLUX PATIENTS (IF NOT HERE FOR REFLUX SKIP TO #3)

HOW LONG HAVE YOU HAD REFLUX? ____________________

WHAT MEDICATIONS ARE YOU TAKING CURRENTLY FOR REFLUX? ____________________

WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST FOR REFLUX? ____________________

HAS ANYONE LOOKED INSIDE OF YOUR STOMACH TO EVALUATE YOUR STOMACH? ____________________

IF SO, WHAT WERE THE RESULTS ____________________

HAVE YOU BEEN TOLD YOU HAVE A HIATAL HERNIA OR STOMACH IN THE CHEST? ____________________

DO YOU HAVE TROUBLE SWALLOWING? ____________________

HAVE YOU EVER HAD A SWALLOWING TEST PERFORMED? ____________________

IF SO, WHAT WERE THE RESULTS ____________________

3. HERNIA PATIENTS

HOW LONG HAVE YOU NOTICED A BULGE OR BEEN TOLD THAT YOU HAVE A HERNIA? ____________________

WHERE IS THE HERNIA LOCATED? ____________________

HAS IT BEEN REPAIRED BEFORE? ____________________

DO YOU EVER HAVE TIMES WHERE YOU NOTICE THE HERNIA IS STUCK OUT? ____________________

IF YES, WHAT DO YOU DO TO HELP? ____________________

HAVE YOU EVER HAD IMAGING DONE TO LOOK AT THE HERNIA? ____________________

PATIENT STATEMENT:

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

SIGNED: ____________________ DATE: __________ TIME: __________