KENNEDY HEALTH ALLIANCE™

Bariatric Surgery History Form

Medical History

Date _____

Name _____ Social Security Number_____-____-_____

DOB _____ Age _____ Height_____ Weight_____ BMI _____

Primary care doctor _____

For office use only

Height ____ Weight ____ BMI _____ Neck _____ Goal _____ Ideal _____

BMI>45____ Age>38____ Apnea_____ HbA1c ____ Insulin ____ Male _____

Past Medical History

Please circle the appropriate response

Bleeding	yes	no	Blood clots in the legs	yes	no
Rheumatic fever	yes	no	Blood clots to the lungs	yes	no
Thyroid problems	yes	no	Diabetes currently	yes	no
Tuberculosis	yes	no	Diabetes while pregnant	yes	no
Urinary tract infections	yes	no	Age at onset of diabetes	_____	
Kidney disease	yes	no	Diabetes control	good	poor
Hepatitis	yes	no	Polycystic ovarian syndrome (PCOS)	yes	no
Do you have to take antibiotics before dental work	yes	no	Problems with anesthesia	yes	no
AIDS/HIV	yes	no	Hypertension (high blood pressure)	yes	no
Sleep Apnea	yes	no	High cholesterol or triglycerides	yes	no

Past Surgical History

Please list all surgeries and approximate dates (year)

Past Hospitalizations

Please list all hospitalizations and approximate dates (year)

Review of Symptoms

General		
Fevers	yes	no
Sweats	yes	no
Fatigue	yes	no
Loss of appetite	yes	no
Bloody sputum	yes	no
Persistent cough	yes	no
Skin		
Rash	yes	no
Skin cancer	yes	no
Senses		
Visual problems	yes	no
Hearing problems	yes	no
Ear ringing	yes	no
Neurological		
Dizziness	yes	no
Migraines	yes	no
Seizures	yes	no
Strokes	yes	no
Memory loss	yes	no
Shaking	yes	no
Numbness	yes	no
Uncoordination	yes	no
Genito-urinary		
Blood in urine	yes	no
Vaginal infections	yes	no
Stress urinary incontinence	yes	no
Bladder/kidney infections	yes	no
Prostate infections	yes	no
Sleep apnea		
Snoring	yes	no
Require C-pap	yes	no
Daytime drowsiness	yes	no
Frequent waking at night	yes	no
Choking at night	yes	no
# of pillows used	_____	
Pulmonary disease		
Short of breath on exertion	yes	no
Hay fever	yes	no
Emphysema/COPD	yes	no
Asthma	yes	no
Aspiration/choking	yes	no

Infection		
HIV	yes	no
AIDS contact	yes	no
TB exposure	yes	no
Swollen glands	yes	no
Recurring infections	yes	no
Skin infections	yes	no
Exercise Limitations		
Mild	yes	no
Moderate	yes	no
Severe	yes	no
Pain in joints		
Back	yes	no
Hips	yes	no
Knees	yes	no
Feet	yes	no
Arthritis	yes	no
Where	_____	
Gastrointestinal		
Heartburn/acid reflux	yes	no
Stomach pains	yes	no
Stomach ulcers	yes	no
Gastritis	yes	no
H. pylori infection	yes	no
Rectal bleeding	yes	no
Liver disease	yes	no
Hepatitis or cirrhosis	yes	no
Colitis or enteritis	yes	no
Stomach surgery	yes	no
Physical limitations		
Climbing stairs	yes	no
Unusual fatigue	yes	no
Airline travel	yes	no
Lifting from floor	yes	no
Use of public seating	yes	no
Personal care	yes	no
Tying shoelaces	yes	no
Playing with children	yes	no
Gynecological		
Last menstrual period	_____	
Pregnancies	_____	
Current contraception	_____	
Any chance you are currently pregnant	yes	no

Review of Symptoms (continued)

Cardiovascular			Psychological		
Heart attack	yes	no	Depression	yes	no
Congestive heart failure	yes	no	Feeling down	yes	no
Thrombophlebitis	yes	no	Suicidal episodes	yes	no
Swelling of ankles	yes	no	Mood swings for days at a time	yes	no
Chest pain	yes	no	Hospitalized for psychiatric reasons	yes	no
Coronary heart disease	yes	no	Use alcohol or drugs to cope	yes	no
Varicose veins	yes	no	Eating disorder	yes	no
Heart murmur	yes	no	Vomiting to lose weight	yes	no
Pulmonary embolism	yes	no	Fasting to lose weight	yes	no
Stroke	yes	no	Laxatives to lose weight	yes	no
Ever taken Fen-Phen	yes	no	Life more stable than a year ago	yes	no
			History of sexual abuse	yes	no
			Psychiatric medications in past or present	yes	no
			Overeat in reaction to feelings	yes	no
			Is your spouse or significant other supportive of weight loss surgery	yes	no
			Age you first became overweight	_____	

Epworth Sleepiness Scale

Note: the Epworth Sleepiness scale refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Scale	Situation	Likelihood
0 = would never doze	Sitting and reading	_____
1 = slight chance of dozing	Watching TV	_____
	Sitting, inactive in a public place	_____
2 = moderate chance of dozing	As a passenger in a car for 1 hour, no break	_____
3 = high chance of dozing	Lying down to rest in the afternoon when circumstances permit	_____
	Sitting and talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In a car, stopped in traffic	_____

Medications

List all daily medications including over-the-counter medications and vitamins, herbs or supplements

Aspirin	yes	no	NSAIDS	yes	no
Ibuprofen	yes	no	Insulin	yes	no
Aleve	yes	no	Steroids	yes	No

Allergies

Please list any known allergies or sensitivities

Medication allergies

Other allergies

Sensitive or allergic to

Latex	yes	no	Iodine	yes	no
Dye	yes	no	Tape	yes	no

Social History

Marital status _ Single _ Married/Partnered _ Divorced/Separated _ Widowed

Religious preference _____

Education_____

Number of people living in your home_____

What type of work do you do_____

Do you smoke	yes	no	Do you drink alcohol	yes	no
How many per day	_____		How many per day	_____	
How much and how often	_____		How much and how often	_____	

Do you use controlled substances yes no

How does your spouse or partner feel about weight loss surgery _____

_____

Family History

Disease	Who in your family had it	When	Was it fatal
Cancer (what type)			
Diabetes			
Heart attack			
Severe obesity			
Other			

Weight Loss History

Please check all that apply.

Non-Supervised Attempts

Body For Life/Bill Phillips		Atkins Diet	
Gloria Marshall		AYDS	
Health spa		Mayo Clinic Diet	
High protein		Pritikin	
Hypnosis		Richard Simmons	
Low carbohydrate		Scarsdale Diet	
Low fat		Stillman Diet	
Calorie counting on my own		Sugar Busters	
Gym membership		Slim Fast	
Home gym equipment		South Beach Diet	
		Other	

Supervised Weight Loss Attempts

Diet Pills From MD		Supervised Calorie Counting	
Diet Shots From MD		Acupuncture	
Diet Center		Psychological Counseling	
Overeaters Anonymous		Weigh Of Life	
Optifast		Weight Loss Center	
Weight Watchers		Exercise Counseling	
Health Management Resources (HMR)		Medifast	
		Metrical	
Nutri-System		Nutritional counseling	
T.O.P.S.		Personal Trainer	
Jenny Craig		Other	
New Direction			
National Weight Loss			

Weight Loss Medications

Acutrim		Obalan	
Adipex-P		Orlistat	
Amphetamines		Phendiet	
Anorex		Phentermine	
Benzphetamine		Phentrol	
Dexatrim		Plegine	
Didrex		Pondimin	
Fastin		Redux	
Fenfluramine		Sanorex	
Herbal Remedies		Tepanol	
Ionamin		Tenuate	
Mazanor		Wehless	
Meridia		Xenical	
Metabolife		Other	

Previous Weight Loss Surgery

Gastric bypass (RNY or other)		Gastric band	
Stomach stapling		Other	
Vertical banded gastroplasty			

Nutrition History

How many meals do you eat daily	_____	
Do you snack between meals	yes	no
Do you drink soda	yes	no
Diet	yes	no
Regular	yes	no
How many sodas do you drink daily	_____	

Food Preferences

Candy	yes	no	Fast food	yes	no
Cookies	yes	no	Seafood	yes	no
Fried food	yes	no	Cakes or pies	yes	no
Pizza	yes	no	Vegetables	yes	no
Chocolate	yes	no	Steak or red meat	yes	no
Chips and snacks	yes	no	Dairy products	yes	No

Food allergies _____

Food Patterns

Please record the type of food and the amount you have eaten over the past two days.

	All foods eaten yesterday	All foods eaten the day before yesterday
Before breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon snack		
Dinner		
After dinner		
Before bed		
Other		