Southern Regional
Physicians Management Group, LLC

BARIATRIC SERVICES
HEALTH HISTORY PROFILE

LAP-BAND ☐ **GASTRIC BYPASS** ☐ **GASTRIC SLEEVE** ☐ **OTHER** ☐

FIRST: ___________________ **MIDDLE INT:** ______ **LAST:** _______________________________

DATE OF BIRTH: ________________________ REFERRING DOCTOR: ____

CELL#: ____________________________ E-MAIL: ____

REASON FOR VISIT: ____

____

EMERGENCY CONTACT PERSONS:

NAME /RELATION: ____ PHONE #: ________________________________

ADDRESS: ____

CURRENT MEDICATIONS:

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

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

MEDICAL HISTORY:

HAVE YOU EVER SUFFERED WITH ANY OF THE FOLLOWING HEALTH PROBLEMS (√ only ones apply)

HEALTH PROBLEMS (√)	**YES**	**HEALTH PROBLEMS (√)**	**YES**
ANEMIA OR BLEEDING DISORDER		HIGH BLOOD PRESSURE	
ANXIETY		HIGH CHOLESTEROL	
ARTHRITIS OR JOINT PAIN		HERNIA (Type)	
ASTHMA		JOINT DISEASE/OSTEOPOROSIS	
BACK PAIN		KIDNEY OR URINARY DISORDER	
CANCER (TYPE)		NEUROLOGICAL DISORDER	
CHRONIC FATIGUE SYNDROME		PARATHYROID	
DEPRESSION		NERVOUS DISORDER	
DIABETES		REFLUX / HEARTBURN	
ECZEMA OR SKIN CONDITION		RESPIRATORY/BREATHING (SOB)	
FIBROMYALGIA or LUPUS		SLEEP APNEA	
GALLSTONES		THYROID (HYPER **OR** HYPO)	
GASTRIC OR DUODENAL ULCER		VARICOSE VEINS OR LEG SWELLING	

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HEART DISEASE (CHF, STROKE, etc)		VISION PROBLEMS/ MIGRAINES	

ALLERGIES: None ☐ LATEX ALLERGY: Yes ☐ No ☐

(INCLUDE MEDICATIONS, FOODS, DRESSINGS)

______________________________REACTION ______________________________
______________________________REACTION ______________________________
______________________________REACTION ______________________________

SURGICAL HISTORY:

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

TYPE OF SURGERY .	DATE

FAMILY MEDICAL HISTORY

PLEASE (√) ALL THAT APPLY	**FATHER**	**DAUGHTER**	**SON**	**MOTHER**	**MG-DAD**	**MG-MOM**	**PG-DAD**	**PG-MOM**	**SIS**	**BRO**
ASTHMA										
ANEMIA OR BLEEDING DISORDER										
CANCER (TYPE)										
DIABETES										
FIBROMYALGIA or LUPUS										
GALLSTONES										
HEART DISEASE (CHF, STROKE, etc)										
HERNIA										
HIGH CHOLESTEROL										
HIGH BLOOD PRESSURE										
OBESITY										
OSTEOPOROSIS										
REFLUX										

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SNORING / SLEEP APNEA										
THYROID DISEASE										
VARICOSE VEINS										
OTHER:										

PULMONARY	**Y**	**N**
Have you ever smoked? *PPD x years:* IF YES, YOU WILL NEED TO STOP SMOKING **TWO** WEEKS BEFORE SURGERY	❑	❑
How often do you smoke cigarettes? Every Day ❑ Some days ❑		
How many cigarettes a day do you smoke? 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 More than 30❑		
Do you smoke your first cigarettes? Within 5 mins ❑ 6-30 mins ❑ 31-60 mins ❑ after 1 hr ❑		
Are you interested in quitting? Ready to Quit ❑ Thinking about Quitting ❑ Not Ready ❑		
Do you have Asthma		
Do you have chronic bronchitis?	❑	❑
Do you have emphysema?	❑	❑
Date of last Flu Vaccine ___________________ last Pneumonia Vaccine _________________		
Have you had pneumonia in past 30 days?	❑	❑
Do you use oxygen at home?	❑	❑
If yes, do you use a CPAP/BiPAP machine?	❑	❑
Do you have problems with your immune system?	❑	❑
Do you have religious or other objections to blood transfusion?	❑	❑
Cultural/Religious Requests	❑	❑

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CARDIAC	**Y**	**N**
How long **have you had high blood pressure**: ______years	❑	❑
Are you on a diuretic (water pill)?	❑	❑
Do you have **chest pain** at rest?	❑	❑
Do you have **chest pain with exercise**?	❑	❑
Have you ever had a **heart attack**? *How many*: ______ *When*? ______________ *Last Cardiologist Visit*_________________	❑	❑
Have you ever had **Congestive Heart Failure**? *When*: _________________________	❑	❑
Do you have a **heart stent**? *When*: ______________________________	❑	❑
Do you have an **irregular heartbeat** or heart rhythm?	❑	❑
Do you have a **heart murmur** or **mitral valve prolapse**?	❑	❑
Have you ever had a **heart valve** replacement? *When*: _________________________ *Which Valve?*__________________________	❑	❑
Do you have a **Pacemaker** or **Defibrillator**?	❑	❑
Have you ever been told that you have a widening of your aorta or that you have an **aortic aneurysm**?	❑	❑
Are you on cholesterol medication?	❑	❑
Have you ever been told you have **peripheral vascular disease?**	❑	❑
Have you ever had an **EKG** test? *Where:* *When:*	❑	❑
Have you ever had a **stress test**? *Where:* *When:*	❑	❑
Have you ever had a **cardiac echo** test? *Where:* *When:*	❑	❑
Have you ever had a **heart catheterization**? *Where:* *When:*	❑	❑

ENDOCRINE/NEURO	**Y**	**N**
Do you have diabetes? Year diagnosed? ____________________	❑	❑
Do you use Insulin?	❑	❑
Do you have thyroid problems?	❑	❑
Have you ever had a stroke? *Date*:___________________	❑	❑
Have you ever had a seizure?	❑	❑
Are you on medication for seizures?	❑	❑
Date of last eye exam? _____________________________		
GENERAL	**Y**	**N**
Any Implants/Location __________________________	❑	❑
Do you have kidney/renal problems?	❑	❑
Are you on dialysis? What days for dialysis? M ❑ T ❑ W ❑ TH ❑ F ❑ SA ❑ SU ❑	❑	❑
Do you have liver problems?	❑	❑
Have you ever had Hepatitis A / B / C / D? *(circle one)*	❑	❑
Do you use recreational Drugs?	❑	❑

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WHAT TYPE? ________________________ HOW OFTEN? ________________		
PSYCHOSOCIAL	**Y**	**N**
Do you drink alcohol? Never ❑ Rarely ❑ Regularly ❑ How many glasses do you drink a day?______________ List type of alcohol you drink (wine, beer liquor, etc.)________________________________		
Do you use recreational drugs? *Which one?* _________________________________ *How often?* Never ❑ Rarely ❑ Daily ❑		
Do you use Herbal Medications? *Which ones?*	❑	❑
Lives: ❑ At Home ❑ Nursing Home ❑ Other: ❑ Alone ❑ With Spouse ❑ With Family ❑ Other		
Cultural/Religious Requests?		
Childhood immunizations: ❑ Yes ❑ No ❑ Unknown		
HEMO/ONC	**Y**	**N**
Do you have bleeding tendencies?	❑	❑
Do you have sickle cell disease or trait?	❑	❑
Do you take any anticoagulants (blood thinners)?	❑	❑
Do you have a history of anemia?	❑	❑
Do you take Aspirin or analgesics regularly?	❑	❑
Do you have a history of cancer?	❑	❑
Are you on chemo? Date of last chemo:	❑	❑
Have you had radiation? Date of last treatment:	❑	❑

MUSCULOSKELETAL	**Y**	**N**
Swelling in legs or feet?	❑	❑
Do you have Lupus?	❑	❑
Do you have Scleroderma?	❑	❑
Do you have joint pain? Where: Back ❑ Knees ❑ Ankles ❑ Feet ❑	❑	❑
Does joint pain limit ability to walk or exercise?	❑	❑
Do you exercise?	❑	❑
What keeps you from exercising? Fatigue ❑ Lack of Time ❑ No Motivation ❑		
Are you willing to change your exercise habits?	❑	❑
Date of last Flu Vaccine ___________________ last Pneumonia Vaccine _________________		
Have you been screen for osteoarthritis? What year? ________________________	❑	❑
Do you use oxygen at home?	❑	❑
If yes, do you use a CPAP/BiPAP machine?	❑	❑

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Do you have problems with your immune system?	❑	❑
Do you have religious or other objections to blood transfusion?	❑	❑
GASTROINTESTINAL	**Y**	**N**
Do you have a history of Reflux or Heartburn? Many times per day ❑ Most nights ❑ Most weeks ❑	❑	❑
What causes your reflux or heartburn? Eating late ❑ Spicy foods ❑ Other ❑ ___________________________________		
Do you have difficulty? Swallowing ❑ Food getting stuck ❑ Hoarseness ❑ Recurrent sore throat ❑ Frequent nausea ❑ Frequent vomiting ❑		❑
Do you have a regular cough at night?	❑	❑
Do you have peptic ulcer disease?	❑	❑
Do you have? Chronic abdominal pain ❑ Chronic diarrhea ❑ Chronic constipation ❑		
Do you have any of these hernias? Hiatal ❑ Inguinal ❑ Umbilical ❑ Ventral ❑		
MALE NA ❑	**Y**	**N**
Do you have urinary incontinence?	❑	❑
Have you been diagnosed with any? Loss of erection ❑ Prostate Cancer ❑ Enlarged Breast ❑		
Date of last prostate exam? ________________________________		
FEMALE NA ❑	**Y**	**N**
Do you have urinary incontinence?	❑	❑
Do you suffer from excess body hair or acne?	❑	❑
Do you have problems with infertility?	❑	❑
Do you have polycystic ovaries?	❑	❑
Date of last Mammogram? ________________________________		

WEIGHT LOSS HISTORY

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

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VITAMINS/SUPPLEMENTS/HERBS:

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

LIST THE VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE: ____
____

ADDITIONAL PHYSICIANS (IF APPLICABLE):

CARDIOLOGIST: ____ PHONES: ____________________________

ENDOCRINOLOGIST: ____ PHONES: ____________________________

ENT (EAR/NOSE/ THROAT): _____________________________________ PHONES: ____________________________

GASTROENTEROLOGIST: ____ PHONES: ____________________________

GYNECOLOGIST: ____ PHONES: ____________________________

INTERNAL MEDICINE: ____ PHONES: ____________________________

NEUROLOGIST: ____ PHONES: ____________________________

NEPHROLOGIST: ____ PHONES: ____________________________

ONCOLOGIST: ____ PHONES: ____________________________

ORTHOPEDIC: ____ PHONES: ____________________________

PRIMARY CARE (PCP) ____ PHONES: ____________________________

PSYCHIATRIST: ____ PHONES: ____________________________

OTHER: ____ PHONES: ____________________________

PHARMACIES (LIST ALL YOU USE)

NAME: ____ PHONES: ____________________________

NAME: ____ PHONES: ____________________________

I have been informed of immediate risks and life-long effects after surgery for:

❑Lap-band ❑Gastric Bypass ❑Gastric Sleeve ❑Hiatal Hernia

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❑Other ____

Did you understand? YES ❑ NO ❑ __________________________________

____

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 QUESTIONAIRE.
COMMENTS:

____

____

❑ This patient is a good Bariatric Surgical Candidate.
❑ This patient is not a good Bariatric Surgical Candidate.

PHYSICIAN SIGNATURE: _______________________ DATE: __________ TIME: _________