Center for Obesity Surgery & Treatment

Medical Arts Building
6400 Newberry Rd., Suite 106 • Gainesville, FL 32605
352-331-5255 • 1-800-342-6057 • Fax: 352-333-6205

All six pages of this history form must be completed and returned prior to making an appointment

Bariatric Patient History Form

Date _____ Ht._____ Wt._____

Name _____ Age _____ Date of Birth _____ Sex _____
(Name as it appears on your driver's license.)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Mailing Address _____ Home Phone _____
Street City County State Zip

911/Street Address _____ Cell Phone _____
Street City County State Zip

Social Security Number _____ E-Mail _____ Work Phone _____

Occupation _____ Employer _____ ☐ Full-time ☐ Part-time

Marital Status _____ Spouse's Name _____ Spouse's Cell Phone _____

Spouse's Work Phone _____

In case of emergency contact (other than Spouse) _____ Relation _____

Address _____ Home Phone _____
Street City County State Zip

Cell Phone _____

Work Phone _____

Name of your Primary Care Physician _____ **Years with Physician** _____

Physician Address _____ Physician Phone _____
Street City County State Zip

Physician Fax _____

Primary Insurance Co. _____	Secondary Insurance Co. _____
Address _____	Address _____
Policy Number _____ Group Number _____	Policy Number _____ Group Number _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Social Security Number _____	Subscriber's Social Security Number _____
Subscriber's Date of Birth _____	Subscriber's Date of Birth _____
Subscriber's Employer _____	Subscriber's Employer _____

NORTH FLORIDA REGIONAL MEDICAL CENTER
Bariatric Patient History Form

MEDICAL HISTORY / REVIEW OF SYSTEMS – Check all that apply

- ☐ Anemia
- ☐ Blood Clots
- ☐ Bleeding Disorder
- ☐ HIV / AIDS
- ☐ Cholesterol Problems
- ☐ Triglyceride Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Irregular Heart Rate
- ☐ History of Heart Murmur
- ☐ Pulmonary Hypertension
- ☐ Congestive Heart Failure
- ☐ History of Rheumatic Fever
- ☐ COPD
- ☐ Emphysema
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Stress Urinary Incontinence
- ☐ Enlarged Prostate
- ☐ Gout
- ☐ Swelling in Legs / Ankles
- ☐ Venous Stasis Disease / Ulcers
- ☐ Liver Problems
- ☐ Hepatitis / Jaundice
- ☐ Cirrhosis
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Neuropathy
- ☐ Migraine Headaches
- ☐ Seizure Disorder
- ☐ History of Stomach Ulcers
- ☐ Gastric Reflux Disease
- ☐ Colitis / Irritable Bowel
- ☐ Gallbladder Problems
- ☐ Thyroid Disease
- ☐ Visual Problems
- ☐ Hearing Problems
- ☐ Depression / Anxiety
- ☐ Confirmed Mental Health Diagnosis
- ☐ Cancer _____

Other Medical Problems: _____

_____

_____

At what age did your periods start: _____ Is it regular: _____ History of pain or heavy flow: _____

At what age did your periods stop: _____ Have you had any bleeding since: _____

Last pelvic Exam: _____ Last PAP smear:_____ Have you had a hysterectomy: Partial ☐ Complete ☐

Pregnancies: _____ Miscarriages: _____ Abortions: _____ Do you use: ☐ IUD ☐ Pill

FUNCTIONAL ASSESSMENT

1. Do you require assistance for ambulation? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other _____
2. Are you able to: Get in and out of bed? ☐ Yes ☐ No Take a bath/shower? ☐ Yes ☐ No
   Climb stairs? ☐ Yes ☐ No Wash your hair? ☐ Yes ☐ No
   Bend down to pick item off floor? ☐ Yes ☐ No

PERSONAL HABITS

1. Do you Smoke: ☐ No ☐ Yes; ☐ Cigarettes ☐ Pipe ☐ Cigars
2. If you smoke, how much do you smoke? _____ packs per day. How long have you smoked? _____ years
3. If you don't smoke, have you smoked in the past? _____ When did you quit?_____
4. How much and how long did you smoke? _____ packs per day, for _____ years.
5. Do you drink alcoholic beverages? ☐ No ☐ Yes If YES, how much? _____
6. Have you ever used illegal drugs? ☐ No ☐ Yes If YES, what? _____

1. Previous Occupation? _____
2. Number of years of school completed? _____
3. Do you have any of the following that may make it hard to learn?

☐ Vision loss ☐ Hearing loss ☐ Physical limits ☐ Emotional problems ☐ Reading problems ☐ Language problems ☐ None

Describe? _____

_____

4. How do you learn best? (check one): ☐ Demonstration ☐ Written ☐ Verbal
5. Preferred Language? ☐ English ☐ Other _____
6. Do you have need for an interpreter? ☐ Yes ☐ No

(One will be provided if needed.)

SUPPORT SYSTEMS/PSYCHOSOCIAL STATUS

1. Number in household? _____
2. Primary emotional support person? (check one): ☐ Self ☐ Spouse ☐ Parent

☐ Other _____

3. Any current major stresses? ☐ No ☐ Yes ☐ Please explain _____

_____

_____

4. Do you have a way to cope with stress? ☐ No ☐ Yes ☐ Please explain _____

_____

_____

5. Are you being abused or neglected? ☐ No ☐ Yes If YES, by whom? _____

Referral to: _____

HEALTH BELIEFS. GOALS. & ATTITUDES / CULTURAL FACTORS / DISCHARGE PLANNING

1. Any concerns regarding your health? ☐ No ☐ Yes ☐ Please explain _____

_____

_____

2. Any religious practices/restrictions? ☐ No ☐ Yes ☐ Please explain _____

_____

_____

Operations / Previous Surgery

Procedure	*Reason*	*Year*	*Hospital*	*City and State*

Other Hospitalizations

Reason	*Year*	*Hospital*	*City and State*

Current Medications

Medication Name	*Strength*	*How Often*	*Reason for Medication*

Have you EVER taken cortisone/steroids? When? _____ Why? _____

Allergies

Medication	*Reaction*	☐ No Known Drug Allergies

Other allergies: (Including Food) _____

NORTH FLORIDA REGIONAL MEDICAL CENTER

Bariatric Patient History Form

Most **insurance companies will require the following information.** This information will be sent along with your initial prior approval letter, therefore expediting approval for surgery.

1. How many years have you been overweight? _____ 2. Lowest Adult Weight? _____ 3. Highest Adult Weight? _____
4. Have you been to:

	Yes	No		Yes	No		Yes	No
Weight Watchers	○	○	Nutri/Systems	○	○	Nutricenter	○	○
T.O.P.S.	○	○	Jenny Craig	○	○	Others	○	○

5. What is the most weight you have lost on one diet? _____ Which diet? _____
6. Place an "X" next to any of the following diet pills you have taken:
   ☐ Fen/Phen ☐ Redux ☐ Adipex ☐ Fastin ☐ Pondimin ☐ Meridia ☐ Other _____
7. Have you been on shots? ○ No ○ Yes If YES, What? _____
8. Are you on a special diet now? ○ No ○ Yes If YES, please describe. _____
9. Have you had any recent weight gain or weight loss? ○ No ○ Yes If YES, how much _____
10. Do you have difficulty chewing / swallowing? ○ No ○ Yes If YES, please describe. _____
11. Do you have a lack of appetite? ○ No ○ Yes If YES, please describe. _____
12. Would you describe your exercise level as: ○ None ○ Light ○ Moderate ○ Strenuous

WHAT DIETS HAVE YOU TRIED?

Diet: _____ Diet: _____
Dates: _____ Dates: _____
Beginning Weight: _____ Beginning Weight: _____
Ending Weight: _____ Ending Weight: _____
Total Weight Loss: _____ Total Weight Loss: _____

Diet: _____ Diet: _____
Dates: _____ Dates: _____
Beginning Weight: _____ Beginning Weight: _____
Ending Weight: _____ Ending Weight: _____
Total Weight Loss: _____ Total Weight Loss: _____

MEDICALLY SUPERVISED WEIGHT LOSS PROGRAMS:

Doctor's Name: _____ Doctor's Name: _____
Address: _____ Address: _____
_____ _____
Dates: _____ Dates: _____
Beginning Weight: _____ Beginning Weight: _____
Ending Weight: _____ Ending Weight: _____
Total Weight Loss: _____ Total Weight Loss: _____

Family History					
Relation	*Age*	*State of Health*	*Obese? (Y/N)*	*Age at Death*	*Cause of Death*
Father:					
Mother:					
Brothers:					
Sisters:					
Spouse:					
Children:					

Any family members with a history of cancer, heart disease, high blood pressure, diabetes, or sickle cell anemia? If YES, please explain.

_____

_____

_____

Please write down in your own words why you feel you need surgery to lose weight.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____