



MEDICAL FACULTY ASSOCIATES
DEPARTMENT OF GENERAL SURGERY
DIVISION OF BARIATRIC SURGERY
1011 NEW HAMPSHIRE AVE, NW
WASHINGTON, DC 20037

New Patient Health Information

*The information obtained from this form is absolutely essential for your surgical consultation.
Without it, your consultation may be postponed.
Please use black ink.*

Name: _____ **Date:** _____
(first, middle initial, last)

Date of birth: _____ **Age:** _____ **Gender:** ___ Male ___ Female

Ethnicity: ___ African-American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Pacific Islander ___ Other

Marital Status: ___ Single ___ Married ___ Partnered ___ Divorced ___ Widowed

Employment Status: ___ Full-time ___ Part-time ___ Homemaker ___ Student ___ Retired ___ Disabled ___ Unemployed

Occupation: _____

What bariatric surgery procedure(s) are you interested in? _____

Are your family and friends supportive of your choice to have surgery? ___ Yes ___ No

If no, why? _____

Have you talked with anyone who has had bariatric (weight loss) surgery? ___ Yes ___ No

Please list all your current health care providers (use other side if necessary):

Name	Address	Telephone
Referring Provider	_____	_____
Primary Care Provider	_____	_____
Cardiologist	_____	_____
Endocrinologist	_____	_____
Pulmonologist	_____	_____
Gastroenterologist	_____	_____
Psychiatrist/Therapist	_____	_____

NUTRITION & EXERCISE HISTORY:

Lowest weight in the last 2 years: _____ Highest weight in the last 2 years: _____

Please list all previous weight loss attempts:

Diets (include all, such as Adkins, LA Weight Loss, Jenny Craig, Weight Watchers, Overeaters Anonymous, etc.). Use other side if necessary.

Name of diet	Year	Length of time	Pounds lost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications (include all such as Meridia, Orlistat (Xenical), FenPhen, Adipex, Metabolife, etc.). Use other side if necessary.

Name of medication	Year	Length of time	Pounds lost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Behavioral Treatments (include all, such as hypnosis, counseling, exercise, acupuncture). Use other side if necessary.

Name of treatment	Year	Length of time	Pounds lost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Weight Loss (include all, such as dietician counseling, physician-prescribed diet, OptiFast,). Use other side if necessary.

Name of program	Year	Length of time	Pounds lost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you describe your eating pattern? (Mark all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Eat large meals | <input type="checkbox"/> Eat before bedtime | <input type="checkbox"/> I actually don't eat too much | <input type="checkbox"/> Secret eating |
| <input type="checkbox"/> Wake up and eat during the night | <input type="checkbox"/> Stress/emotional eating | <input type="checkbox"/> Binge eating | <input type="checkbox"/> Skip meals |
| <input type="checkbox"/> I follow a healthy diet | <input type="checkbox"/> Nibble throughout the day | <input type="checkbox"/> Rarely feel full | <input type="checkbox"/> Always feel hungry |

Indicate which foods you prefer (which foods would most likely make you go off a diet):

- | | | | |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> soda/soft drinks | <input type="checkbox"/> French fries | <input type="checkbox"/> pizza | <input type="checkbox"/> chips/salty snacks |
| <input type="checkbox"/> steak/chops | <input type="checkbox"/> candy | <input type="checkbox"/> fried foods | <input type="checkbox"/> potatoes |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> pasta | <input type="checkbox"/> cakes/pies | <input type="checkbox"/> cookies |
| <input type="checkbox"/> cream sauces/gravies | <input type="checkbox"/> salad dressings | <input type="checkbox"/> ice cream | |

How would you describe your exercise? Never Some Days Most Days

What type of exercise do you enjoy?

What prevents you from exercising? _____

MEDICAL HISTORY:

Please check all that apply. Use other side of paper if necessary.

Cardiovascular

- | | | |
|---|--|---|
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> edema / swelling of legs |
| <input type="checkbox"/> heart valve disease | <input type="checkbox"/> heart attack | <input type="checkbox"/> phlebitis of legs |
| <input type="checkbox"/> abnormal EKG | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> cellulitis of legs |
| <input type="checkbox"/> TIA (mini-stroke) | <input type="checkbox"/> blood clots / DVT / PE | <input type="checkbox"/> discoloration / ulcers of legs |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> other |
| | <input type="checkbox"/> stroke (CVA) | |

Pulmonary

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pulmonary hypertension | <input type="checkbox"/> use oxygen |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> asthma | <input type="checkbox"/> other |
| <input type="checkbox"/> COPD | <input type="checkbox"/> sleep apnea | |

Metabolic

- | | | |
|---|--|---|
| <input type="checkbox"/> elevated blood sugar | <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> gout | <input type="checkbox"/> high cholesterol / lipids | <input type="checkbox"/> other |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> steroid use | |

Gastrointestinal

- | | | |
|---|--|--|
| <input type="checkbox"/> nausea / vomiting | <input type="checkbox"/> hepatitis | <input type="checkbox"/> peptic ulcers |
| <input type="checkbox"/> constipation | <input type="checkbox"/> NASH | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> cirrhosis | <input type="checkbox"/> gallstones |
| <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> heartburn / GERD | <input type="checkbox"/> other |
| <input type="checkbox"/> GI bleeding | <input type="checkbox"/> swallowing difficulties | |

Musculoskeletal

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> arthritis | <input type="checkbox"/> joint replacement |
| <input type="checkbox"/> joint pain | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> other |
| <input type="checkbox"/> back pain | | |

Do you use a cane or walker when away from home? Yes No

Do you use a wheelchair when away from home? Yes No

Neurologic

- | | | |
|--|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> pseudotumor cerebri | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> seizures | <input type="checkbox"/> neuropathy | <input type="checkbox"/> other |
| <input type="checkbox"/> muscle weakness | | |

Psychosocial

- | | | |
|--|---|--|
| <input type="checkbox"/> anxiety/nervousness | <input type="checkbox"/> eating disorder | <input type="checkbox"/> psychosis |
| <input type="checkbox"/> depression | <input type="checkbox"/> bipolar disorder | <input type="checkbox"/> schizophrenia |

Reproductive (female)

- menstrual irregularities
 PCOS (polycystic ovarian syndrome)

Other

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> anemia | <input type="checkbox"/> hearing problems | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> stress urinary incontinence | <input type="checkbox"/> vision problems | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> other |
| <input type="checkbox"/> kidney stones | | |
| <input type="checkbox"/> trouble urinating | | |

SURGICAL HISTORY:

	Date	Hospital	Surgeon
History of previous weight loss surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What type?			
What was your weight before the surgery?			
What was your lowest weight after surgery?			
Did you have complications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what kind?			

Please list your previous surgeries	Date	Hospital	Surgeon

Have you ever had a problem with surgery or anesthesia? Yes No If yes, explain:

MEDICATIONS:

Please list your medications (including vitamins, herbal supplements, aspirin and other over-the-counter medications)

Drug Name	Dose	How often

Drug Allergy	Reaction

Other Allergy	Reaction

FAMILY HISTORY:

What medical problems run in your family?

Obesity Heart disease Kidney disease Liver disease Colon cancer
 Diabetes Lung disease Blood clots Breast cancer Hypertension

Family Member	Age	Health Problems	If deceased, age at death & cause
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling:			
Sibling:			
Sibling:			
Sibling:			

SOCIAL HISTORY:

Do you **smoke**? No Yes How many packs per day? _____ How long have you smoked? _____ years
 Did you smoke in the past? Yes No When did you quit? _____

Do you consume **alcohol**? No Yes How many drinks per week? _____

Do you use recreational **drugs**? No Yes If yes, what do you use? _____
 When was the last time you used? _____

Did you use drugs in the past? No Yes When did you stop? _____