NEW PATIENT QUESTIONNAIRE Bariatric	Boston, MA 02215		MED. REC. #	
Primary Care Physician:	-	NAIRE		
Primary Care Physician:	I am interested in: 🔲 Gastric Bypa	ass 🗌 Lap Ba	nd 🗌 Gastric S	Sleeve 🗌 Not Sure
Primary Care Physician: Phone: ()				
Psychopharmacologist:	Primary Care Physician) -
Psychopharmacologist:				,
Do you have a history of any of the following conditions? (check all that apply) Diabetes Blood clots Gastro esophageal reflux (GER Hypoglycemia Leg swelling Colon (hemorrhoids, polyps) Hypothyroidism Peripheral vascular disease Celiac disease Thyroid disease Numbness or tingling in hands / feet Hearburn Kidney disease Migraines Crohn's disease Kidney disease (hepatitis, cirrhosis) Impaired mobility (e.g. trouble walking) Ulcerative colitis Liver disease (hepatitis, cirrhosis) Impaired mobility (e.g. trouble walking) Ulcerative colitis Depression High blood pressure Infertility Panic attacks Chest pain / angina Polycystic Ovary Syndrome Past suicide attempts Coronary heart failure Anemia (iron deficiency) Schizophrenia Congestive heart failure Gout Bipolar disorder High cholesterol Prostate issues Borderline personality disorder Asthma Steep apnea Bing eating Shortness of breath Stroke Vomiting / purging COPD Arthritis Anorexia Pulmonary embolism Other:	Therapist of Mental Health Counseld	Л	PII0I	ne. ()
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PATIENT'S NAME

Beth Israel Deaconess Medical Center

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NEW PATIENT QUESTIONNAIRE Bariatric

PATIENT'S NAME	
MED. REC. #	
DOB	

Family History

Please indicate if your parents, siblings, and/or your children have had any of the following conditions and at what age they got the condition.

MR2806		Which Family Member?	At What Age?	Living or Deceased?
12806	Heart Disease			
MF	High Cholesterol / Lipids			
	Diabetes			
	Stroke			
	Obesity			
	Arthritis			
	TB (Tuberculosis)			
	Thyroid Disease			
	Asthma			
	Cancer			

Past Surgical History: Have you ever had any operations or surgical procedures? No Yes If Yes, please list.			
Date	Operation / Procedure		
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MEDICATIONS: List all the prescription and over-the-counter medicines that you take at home (such as cold medicine, herbals, vitamins and nutritional supplements). If you have received a printed Medication list, please add anything here that is not on your printed list.

I take no medicatio	ns or supplements
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See attached list

Medication / Supplement Name	Dose	How You Take It (by mouth, injection,	Lime of Day / How Offer	
Do you smoke? No Yes If Yes, how many packs per day?For how many years?				
Do you drink?				
Do you use Recreational Drugs?				
MR 2806 OP (10/14)			Page 2 of 3	

Beth Israel Deaconess Medical Center Boston, MA 02215	PATIENT'S NAME			
NEW PATIENT QUESTIONNAIRE Bariatric	DOB Patient Identification			
Have you tried any of the following? (Check all the Weight Watchers® Medifast® Nutritionist / Dietitian Atkins® Sibutramine (Meridia®) Ephedra Acupuncture The Zone Orlistat (Xenical TM) Dexatrim Fen-Phen Optifast® LA Weight Loss® HMR Phentermine(Fastin®, Adipex®) South Bea Other over the counter diet aids / herbs What food triggers do you feel contributed to your	 Amphetamines Slimfast Diet Workshop Nutrisystem® Topiramate (Topamax®) Metabolife OA Pondimin Hypnosis TOPS Trimspa® Other Surgery Laxatives Psychotherapy and Behavior Therapy Jenny Craig Previous Gastric Surgery / Stomach stapling 			
In your opinion, what are the factors that contribute to your excess weight? (Check all that apply) Portion size Emotional eating Compulsive eating Genetics Eating too many fats and/or carb Lack of knowledge about healthy living Who will be your Support Persons for after surgery? Name: Relationship:				
Functional Health Status Independent – no help needed to complete activitie Partially Dependent – some help needed Totally Dependent on others for self-care	ies of daily living			
Patient Certification: I have answered these question information will be used to guide my care. X	Print Name			
Physician Review: I have reviewed the above informat				
X M.D. Signature	Print Name / / / Time (24 hour)			

MR 2806 OP (10/14)