

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. _____

Address _____

Policy Number _____ Group Number _____

Subscriber's Name _____

Subscriber's Social Security Number _____

Subscriber's Date of Birth _____

Subscriber's Employer _____

Secondary Insurance Co. _____

Address _____

Policy Number _____ Group Number _____

Subscriber's Name _____

Subscriber's Social Security Number _____

Subscriber's Date of Birth _____

Subscriber's Employer _____

NORTH FLORIDA REGIONAL MEDICAL CENTER
Bariatric Patient History Form



MEDICAL HISTORY / REVIEW OF SYSTEMS – Check all that apply

| | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> History of Rheumatic Fever | <input type="checkbox"/> Degenerative Joint Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> COPD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Asthma | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Triglyceride Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> History of Stomach Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stress Urinary Incontinence | <input type="checkbox"/> Gastric Reflux Disease |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Colitis / Irritable Bowel |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Swelling in Legs / Ankles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Venous Stasis Disease / Ulcers | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> History of Heart Murmur | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Confirmed Mental Health Diagnosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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: <input type="checkbox"/> Partial <input type="checkbox"/> Complete |
| Pregnancies: _____ | Miscarriages: _____ | Abortions: _____ |
| Do you use: <input type="checkbox"/> IUD <input type="checkbox"/> Pill | | |

FUNCTIONAL ASSESSMENT

- Do you require assistance for ambulation? None Cane Walker Wheelchair Other _____
- 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

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

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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 _____

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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 | <input type="radio"/> | <input type="radio"/> | Nutri/Systems | <input type="radio"/> | <input type="radio"/> | Nutricenter | <input type="radio"/> | <input type="radio"/> |
| T.O.P.S. | <input type="radio"/> | <input type="radio"/> | Jenny Craig | <input type="radio"/> | <input type="radio"/> | Others | <input type="radio"/> | <input type="radio"/> |
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: _____
 Dates: _____
 Beginning Weight: _____
 Ending Weight: _____
 Total Weight Loss: _____

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

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

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

MEDICALLY SUPERVISED WEIGHT LOSS PROGRAMS:

Doctor's Name: _____
 Address: _____

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

Doctor's Name: _____
 Address: _____

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

**NORTH FLORIDA REGIONAL MEDICAL CENTER
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| Family History | | | | | |
|-----------------|------------|------------------------|-------------------------|---------------------|-----------------------|
| <i>Relation</i> | <i>Age</i> | <i>State of Health</i> | <i>Obese? (Y/N)</i> | <i>Age at Death</i> | <i>Cause of Death</i> |
| 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 _____

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