University of Nebraska Medical Center
Bariatric Surgery Patient Personal Information Form

For Office Use Only

Weight: _____ Height: _____ BMI:_____

IBW: ____ kg; _____ lbs. EBW: _____ %IBW:

Amount of weight to be lost prior to surgery: _____

__ Adjustable Gastric Band __ Gastric Bypass (__ Lap __ Open) ___ Sleeve

Patient Name: _____ Date of Birth: _____

Please fill out the following questions. I understand that some of this is difficult to talk about, but a complete history is very important to your evaluation. I am repeatedly told that the dietary history is the hardest part because it makes patients remember all the problems that they have had with their weight over the years. I do not ask these questions to make you feel bad, but I ask them because it is important to understand what you have tried in the past. Many insurance companies require this information so by having this completely filled out; it allows me to submit the most accurate information to your insurance carrier in an effort to get approval.

Thank you,

Dr. Goede, Dr. McBride and Dr. Oleynikov

Please list all of the physicians you are currently seeing

Physician's Name	Physician's Specialty	Address, City, State & Zip	Phone number and Fax number for Doctor

Please list your Health Insurance information below

Insurance Carrier	**Address, City, State & Zip**	***Phone Number* and *FAX Number* for Insurance Customer Service**

What is your goal weight? _____ pounds

What was your weight at age 18? _____ pounds

How did you hear about us? _____

If applicable, your weight when you became pregnant for the first time? _____ pounds

Race: _____

Please list three health related reasons why you want surgery.

1.

2.

3.

Please list three other reasons why you want surgery.

1.

2.

3.

Current weight: _____ Height: _____
(If you do not know your height and weight, please see your primary doctor to have this checked.)

List all the **diets** you have tried in the past 5 years,
including name of physician supervised weight loss, if this was prescribed

Date	Diet Type	Weight Lost (lb.)	Regained? (lb.)

Supervising Physician's Name: _____

Do you exercise regularly? ___ Yes ___ No If yes, what type of exercise and how often?

_____

If you do not exercise, what prevents you from exercising now? _____

Do you have:			**How long?**
Arthritis/Degenerative Joint Disease	Yes	No	_____
Diabetes	Yes	No	_____
Shortness of Breath with exertion	Yes	No	_____

When walking up stairs, how many steps can you climb before noticing shortness of breath?

_____ Steps / Flights (enter number and circle one)

When do you have to stop and rest? After _____ Steps / Flights (enter number and circle one)

How long do you have to rest before you can talk? ____ min. before you can walk? ____ min.

Do you have:			**How long?**
High Cholesterol or Lipids	Yes	No	_____
Reflux	Yes	No	_____
Migraine Headaches	Yes	No	_____
High Blood Pressure	Yes	No	_____
Irregular menstrual cycle (women)	Yes	No	_____
Joint pain	Yes	No	_____
Pseudotumor cerebri	Yes	No	_____
Sleep Apnea	Yes	No	_____
Urinary incontinence	Yes	No	_____
Venous stasis disease	Yes	No	_____

Do you have:			**How long?**
Heart Attack	Yes	No	_____
Stroke	Yes	No	_____
Emphysema	Yes	No	_____
Asthma	Yes	No	_____
Cancer	Yes	No	_____
Ulcers	Yes	No	_____
Kidney Stones	Yes	No	_____
Depression	Yes	No	_____
Bipolar Disease	Yes	No	_____
Fibromyalgia	Yes	No	_____

Other condition(s) for which you see a physician _____

List all **operations** you have had.

Year

1.

2.

3.

4.

List all **medications** you are currently taking, include all over –the-counter medications

1.

2.

3.

4.

5.

6.

7.

8.

9.

10

Are there any medications you are "supposed" to be taking but are not? YES NO

List Medications here: _____

Have you ever taken Phen-Fen? Yes ___ No ___ If so, FROM WHEN to WHEN? _____

List any medications you have had an **allergic reaction** to, include the type of reaction (i.e. rash, itching, difficulty breathing…)
1.

2.

Family history- please give us information about the health of your relatives

Relative	Current age or Age at death	Health problems	Overweight
Mother			Y/N
Father			Y/N
Brother(s)			Y/N
Sisters(s)			Y/N
Children			Y/N

Marital status: Are you currently married? ___ Yes ___ No If yes, how long? _____

Is this your first marriage? ___ Yes ___ No If no, how many previous marriages? ____

On a scale of 1 to 5 (1 = least happy), how happy are you in your present marriage? ____

Employment status

Are you currently employed? ___ Yes ___ No

If yes, how long have you been employed? _____ years _____ months

On a scale of 1 to 5 (1 = least happy), how happy are you in your present job? _____

On a scale of 1 to 5 (1 = least happy), how would you rate your overall satisfaction with

yourself? _____

___ Disabled-reason for disability _____

Onset of disability _____ Occupation prior to disability _____

Please answer the following questions by checking the answer

	YES	NO
Do you smoke cigarettes, cigars, and a pipe or chew tobacco?	☐	☐
Packs per day _____		
If you quit, when did you quit? Date _____		
Do you drink alcohol? Amount per week _____	☐	☐

	YES	NO
Have you had a fever in the past 2 weeks?	□	□
Are you taking any over the counter medication to help you lose weight? If yes, please list on the medication list above, page 4.	□	□
In the past 2 weeks have you had a runny nose, sore throat or cough?	□	□
Do you often have ringing in your ears?	□	□
Do ever have double vision?	□	□
Have you ever had chest pain?	□	□
Have you ever felt you heart beating in your chest?	□	□
Have you ever seen a Cardiologist (heart specialist), had any heart tests, had a heart attack or any other heart problems?	□	□
Do you have shortness of breath or trouble breathing?	□	□
Do you have asthma or "wheezing" problems?	□	□
Do you snore?	□	□
Do you wake up with a headache?	□	□
Have you ever fallen asleep at the wheel?	□	□
Do you take a nap every day?	□	□
Do you feel rested when you wake up in the morning?	□	□
Do you ever wake up from a deep sleep choking?	□	□
Has anyone ever told you that you stop breathing while you are sleeping?	□	□

In what position do you sleep? __ Sitting up __ Lying flat on back __ Lying on side __ Lying on stomach

How may pillow do you use under your head? _____

How often do you awaken from sleep to catch your breath? _____

	YES	NO
Have you ever had a sleep study?	☐	☐
If you have sleep apnea, do you use a C-pap or Bi-pap?	☐	☐
What are the settings? _____		
Do you ever have heartburn?	☐	☐
How many times does it happen?		
_____ Less than once per week		
_____ 1-2 times per week		
_____ 3-4 times per week		
_____ 5 times per week or more		
Do you take medications for heartburn?	☐	☐
If yes, please list on the medication list above, page 4.		
Do you have pain with swallowing?	☐	☐
Have you ever had blood in you urine?	☐	☐
Do you ever leak urine when you cough, sneeze or laugh?	☐	☐
If yes, do you wear a pad for protection?	☐	☐
Do you have arthritis?	☐	☐
If you take medication, please list on the medication list above.		
Do you have pain in your back?	☐	☐
Do you have pain in your hips?	☐	☐
Do you have pain in your knees?	☐	☐
Do you have pain in your ankles?	☐	☐
Do you have pain in your feet?	☐	☐
Do you have swelling in your legs?	☐	☐
Have you ever had an ulcer or non-healing sores on your legs?	☐	☐
Do you have any rashes?	☐	☐
Do you get yeast infections or other infections of your skin?	☐	☐
If yes, on what part of your body? _____		
Have you ever noticed a breast mass or had breast cancer?	☐	☐
Do you have chronic and/or severe headaches?	☐	☐

	YES	NO
Have you ever had a seizure?	☐	☐
Have you ever had a serious problem with depression or anxiety?	☐	☐
If yes, have you ever been hospitalized for it?	☐	☐
If you take medication, please list on the medication list above.		
Are you seeing a mental health counselor, psychologist, or psychiatrist?	☐	☐
Have you ever taken medication for your nerves?	☐	☐
Are you taking anything now?	☐	☐
If yes, please list on the medication list above.		
Have you ever attempted suicide?	☐	☐
If so, when? _____		
Have you ever had a drinking problem or been told to cut down?	☐	☐
Do you eat a large quantity of foods in a short period of time?	☐	☐
Do you feel "out of control" when you eat?	☐	☐

REPRODUCTIVE SYSTEMS – FEMALES

At what age did your periods start? _____

Have you gone through menopause? ___ Yes ___ No If yes, at what age? _____

Are your periods: ___ Regular ___ Irregular

What was the date of your last menstrual period? _____ Any cramping? ___ Yes ___ No

Have you ever been pregnant? ___ Yes ___ No If yes, how many children? _____

Any miscarriages? ___ Yes ___ No

Have you ever been told you had a thyroid or "glandular" problem?	☐	☐
Have you ever had anemia, or "low iron" or "low blood counts"?	☐	☐
Have you ever had a bleeding problem?	☐	☐
Do you have any religious or other objections to blood transfusion?	☐	☐

	YES	NO
Do you have any seasonal or pet allergies?	□	□
Have you ever taken steroids for any reason?	□	□

When was the last time you took steroids? _____

PERSON TO NOTIFY IMMEDICATELY FOLLOWING SURGERY:

Name: _____

Relationship: _____

Phone: (Check where to call) ____ Home _____ ____ Work _____

Will he/she be waiting at the hospital during your surgery? _____ Yes _____ No

Revised: 6/4/09