MISH
THE INSTITUTE FOR ADVANCED BARIATRIC SURGERY
The Premier Hospital for Comprehensive Bariatric Care

WLS PATIENT MEDICAL HISTORY FORM

Name: _____ **DOB:** _____ **Age:** _____

Email Address: _____

PRESENT ILLNESS (Please answer all the questions listed below)

1. In your own words, state your reason for coming to see the doctor today (chief complaint):_____

2. Have you seen other doctors for weight loss surgery or weight loss? Who? _____

3. How long has excess weight been a problem? _____

4. Can you identify health problems or quality of life issues directly related to the excess weight? _____

5. On a scale of 0-10 (low to high), how severe would you rate your excess weight? _____

6. On a scale of 0-10 (low to high), how would you rate the impact of excess weight on your health and/or quality of life? _____

7. How frequently does the excess weight impact your health and/or quality of life? _____

8. How have you learned to deal or cope with the excess weight? _____

9. Can you identify a health problem or life-style issue that may be contributing to the problem of excess weight? _____

10. Is the problem of excess weight potentially related to another health issue? _____

11. What has worked in the past to help you lose weight? _____

12. What has not worked in the past to help you lose weight? _____

OTHER DOCTORS (Please list other doctors who have been involved in your medical care)

	Doctor Name	Type of Doctor (reason seen)	Office Telephone
1. Dr.			
2. Dr.			
3. Dr.			

4. How many times have you seen your primary care doctor in the last 2 years? _____

5. How many times have you been in the emergency room in the last 2 years? _____

Name: _____ **DOB:** _____

MEDICAL HISTORY (Please check [X} all medical conditions you have or have had in the past.)

- Chronic Pancreatitis
- Cirrhosis
- Crohn's
- Lupus Erythematosus
- Myasthenia Gravis
- Multiple Sclerosis
- Portal Hypertension
- Alcoholism
- Arthritis
- Asthma
- Back Pain
- Blood Clots
- Breast Cancer
- Colon Cancer
- Depression
- Diabetes or Pre-Diabetes
- Esophageal dysmotility
- Gallbladder disease
- Heart Disease
- Heartburn/Reflux
- Hiatal Hernia
- High Blood Pressure
- High Cholesterol
- High Triglycerides
- Hip, Knee, Ankle, Foot Problems
- Infertility
- Liver Disease
- Polycystic Ovarian Syndrome
- Prostate Cancer
- Shortness of Breath with Exertion
- Sleep Apnea
  - CPAP
  - Bi-PAP
- Stroke
- Thyroid Disease
- Urinary Stress Incontinence
- Uterine Cancer
- Varicose Veins
- Other: _____ _____

Additional Medical History (Please check all medical conditions you have or have had in the past.)

- AIDS
- Anemia
- Anxiety
- Bleeding Disorder
- Breast Mass
- Bronchitis
- Bulimia
- Cancer (Type) _____ _____
- Chemical/Drug Dependency
- Clotting Problems
- Colitis
- Deep Vein Thrombosis (DVT)
- Diabetes
- Emphysema
- Epilepsy
- Fibromyalgia
- Goiter
- Gonorrhea
- Gout
- Heart Murmur
- Hepatitis
- Herpes
- HIV Positive
- Immune System Disorders
- Irregular Heartbeat
- Irritable Bowel
- Kidney Disease
- Migraines/Headaches
- Multiple Sclerosis
- Pacemaker
- Pneumonia
- Prostate Problems
- Psychiatric Care
- Pulmonary Embolism
- Reaction to Anesthesia
- Rheumatic Fever
- Scleroderma
- Seizure Disorder
- Sinus Infections
- Sjogrens Syndrome
- Stomach Ulcers
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Vaginal Infections
- Venereal Disease
- Other: _____

SURGICAL HISTORY (Please list all surgical procedures you have had in the past)

	NAME OF OPERATION	YEAR		NAME OF OPERATION	YEAR
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

FAMILY MEDICAL HISTORY (Please check [x] all medical conditions your blood relatives have.)

- AIDS
- Alcoholism
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Disease
- Cancer
- Clotting Disorders
- Colitis
- Crohn's
- Depression
- Diabetes
- Emphysema
- Heart Disease
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Stroke

Other: _____

SOCIAL HISTORY (Please answer all the questions below)

Occupation: _____ Marital Status: _____

Do you smoke?	Yes	No	Have you quit?	Yes	No
Do you or did you drink excessive alcohol?	Yes	No	Have you quit?	Yes	No
Do you use or have you used recreational drugs?	Yes	No	Have you quit?	Yes	No

Name: _____ **DOB:** _____

DRUG ALLERGIES – REACTIONS (Please list all drug allergies and type of reaction.)

_____

_____

_____

Pharmacy name and telephone number: _____

MEDICATIONS (Please list all prescription medications, over the counter medications, vitamins and supplements as well as any herbal supplements that you are currently taking.)

Drug Name	Dose	Frequency	Route	Reason for Taking

Name: _____ **DOB:** _____

REVIEW OF SYSTEMS (Please check **[x]** symptoms that you have had or may be experiencing)

General/Constitution
- Decreased appetite
- Fatigue
- Fever
- Weight - Gain/Loss

Skin/Breast
- Breast mass
- Hives
- Nipple discharge
- Rashes

Ear, Nose & Throat
- Bleeding gums
- Constant throat clearing
- Difficulty swallowing
- Frequent sore throat
- Hoarseness
- Loss of hearing
- Mouth Sores
- Nasal congestion
- Nosebleeds
- Ringing in ears

Hematological
- Bleeding tendency
- Clotting tendency

Eyes
- Pain
- Loss of vision
- Double vision
- Blurred vision
- Flashing spots/light
- Glasses

Cardiovascular
- Chest pain with activity
- Chest pain at rest
- Heart palpitations
- Irregular heart beat
- Leg swelling
- Shortness of breath with activity
- Shortness of breath at rest

Respiratory
- Chronic cough
- Coughing up blood
- Home O_2 (oxygen)
- Pneumonia
- Pulmonary Embolism
- Night Sweats
- Wheezing

Gastrointestinal
- Nausea
- Vomiting blood
- Heartburn
- Regurgitation
- Difficulty swallowing
- Pain with swallowing
- Constipation
- Yellow jaundice
- Stomach pain
- Blood in stools
- Black tarry stools
- Hemorrhoids
- Need for laxative/enema use
- Diarrhea

Genitourinary
- Difficult urination
- Blood in urine
- Discharge from penis/vagina
- Frequent night urination
- Frequent urination
- Kidney Stones
- Painful urination
- Prostate troubles
- Urgency
- Anemia

Neurological
- Arm / Leg weakness
- Convulsions
- Dizziness
- Fainting
- Headaches
- Memory Loss

Endocrine
- Fingernail changes
- Flushing
- Heat/cold intolerance
- Increased thirst
- Increased salt intake

Immunologic
- Latex allergy
- Rhinitis
- Skin sensitivity

Psychiatric
- Depression
- Panic attacks
- Psychological counseling

IN THE LAST 5 YEARS HAVE YOU HAD: (Please check (X) all that apply.)

Heart work-up / tests	Yes	No		
• Echo	Yes	No	Date: _____	Location: _____
• Stress Test	Yes	No	Date: _____	Location: _____
• Cardiac Catherization	Yes	No	Date: _____	Location: _____
Lung work-up / tests:	Yes	No		
• Chest X-ray	Yes	No	Date: _____	Location: _____
• Pulmonary Function Tests	Yes	No	Date: _____	Location: _____
• Coumadin/Lovenox	Yes	No	Date: _____	Location: _____

IMPORTANT REMINDERS

Did you check if your insurance company covers weight loss surgery? No Yes:_____

What type of provider does your insurance company consider us as: in network out of network non-participating preferred

Do you have a copy of your insurance pre-certification criteria for weight loss surgery? No Yes_____

Name: _____ **DOB:** _____

DIETING HISTORY – Last 2 years only (***Must be filled out*** – list all diet and exercise attempts, use extra sheet if needed.)

Diet Program (Diet programs/exercise/drugs)	**Year**	**Supervised** (By a M.D. / Dietician)	
Diet Programs:			
Advocare		Yes	No
American Diabetic		Yes	No
American Heart Association		Yes	No
Atkins		Yes	No
Blood Type		Yes	No
Body for Life		Yes	No
Cabbage Soup		Yes	No
Diet Center		Yes	No
E-Diet		Yes	No
Fit for Life		Yes	No
Grapefruit		Yes	No
Health Strategies		Yes	No
High Protein		Yes	No
Hollywood Liquid		Yes	No
Jenny Craig		Yes	No
LA Weight Loss		Yes	No
Low Calorie		Yes	No
Low Carbohydrate		Yes	No
Low Fat		Yes	No
Metabolic Type		Yes	No
Michael Thurmond		Yes	No
Nutrisystem		Yes	No
Omni-Trim		Yes	No
Optifast		Yes	No
Out-of-Eden		Yes	No
Physician's Weight Loss		Yes	No
Rachel Ray		Yes	No
Release the Fat		Yes	No
Scarsdale		Yes	No
Six-Week Body Makeover		Yes	No
Slim-4-Life		Yes	No
Slimfast		Yes	No
Starvation		Yes	No
Suzanne Summers		Yes	No
Tops		Yes	No
Weight Watcher's		Yes	No
Zone		Yes	No
Other: _____		Yes	No

Diet Program (Diet programs/exercise/drugs)	**Year**	**Supervised** (By a M.D. / Dietician)	
Prescription Medications:			
Adipex		Yes	No
Didrex		Yes	No
Fhen-Phen		Yes	No
Ionamin		Yes	No
Meridia		Yes	No
Phentermine		Yes	No
Tenuate		Yes	No
Xenical		Yes	No
Over-the-Counter Meds:			
AB-B-Gone		Yes	No
Alli		Yes	No
Cortislim		Yes	No
Dexatrim		Yes	No
Envy		Yes	No
Ephedra		Yes	No
Fahrenheit		Yes	No
Fastin		Yes	No
Flush the Fat		Yes	No
Ginko Biloba		Yes	No
Ginseng		Yes	No
Grapefruit pills		Yes	No
Green Tea pills		Yes	No
Herbal Life		Yes	No
Hoodia		Yes	No
Hydroxycut		Yes	No
Leptopril		Yes	No
Lipozene		Yes	No
Medifast		Yes	No
Metabolife		Yes	No
Relacore		Yes	No
Slim Quick		Yes	No
Stacker-2		Yes	No
Trimspa		Yes	No
Xenidrine		Yes	No
Zantrex-3		Yes	No
Exercise:			
Bally / Gold's Gym		Yes	No
Curves		Yes	No
YMCA		Yes	No
Other: _____		Yes	No

OTHER PHYSICIAN SUPERVISED DIETS: (Please list any other physician supervised diets you have attempted.)

_____

_____

_____

_____

Name: _____ **DOB:** _____

In order to obtain pre-certification for your weight loss surgery operation the surgeon has to submit a Letter of Medical Necessity. The Letter of Medical Necessity is a letter written by a doctor to your medical insurance company requesting permission for a weight loss surgery operation. Often your personal answers below help the doctor in writing a stronger letter on your behalf.

WHAT ARE YOUR EXPECTATIONS FROM WEIGHT LOSS SURGERY? (Please write legibly)

DOES YOUR EXCESS WEIGHT PLACE LIMITATIONS ON YOUR DAILY ACTIVITIES SUCH AS WALKING, TYING SHOES, OR MAINTAINING PERSONAL HYGIENE? (Please write legibly)

I have completed this form to the best of my ability. I understand that I will be required to meet with a Surgeon prior to surgery. This information will be used to assist in the pre-determination process for my surgery through my insurance company should I pursue this avenue or if I choose to be self-pay.

Signature: _____ **Date:** _____