MEDICAL FACULTY ASSOCIATES
DEPARTMENT OF GENERAL SURGERY
DIVISION OF BARIATRIC SURGERY
2150 PENNSYLVANIA 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)

_____ Eat large meals	_____ Eat before bedtime	_____ I actually don't eat too much	_____ Secret eating
_____ Wake up and eat during the night	_____ Stress/emotional eating	_____ Binge eating	_____ Skip meals
_____ I follow a healthy diet	_____ Nibble throughout the day	_____ Rarely feel full	_____ Always feel hungry

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

_____soda/soft drinks	_____French fries	_____pizza	_____chips/salty snacks
_____steak/chops	_____candy	_____fried foods	_____potatoes
_____chocolate	_____pasta	_____cakes/pies	_____cookies
_____cream sauces/gravies	_____salad dressings	_____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

_____**congestive heart failure**
_____heart valve disease
_____abnormal EKG
_____TIA (mini-stroke)
_____circulation problems
_____**high blood pressure**
_____**heart attack**
_____**coronary artery disease**
_____**blood clots / DVT / PE**
_____**chest pain / angina**
_____**stroke (CVA)**
_____edema / swelling of legs
_____phlebitis of legs
_____cellulitis of legs
_____discoloration / ulcers of legs
_____other

Pulmonary

_____shortness of breath
_____pneumonia
_____**COPD**
_____**pulmonary hypertension**
_____**asthma**
_____**sleep apnea**
_____**use oxygen**
_____other

Metabolic

_____elevated blood sugar
_____gout
_____kidney disease
_____**diabetes**
_____**high cholesterol / lipids**
_____**steroid use**
_____thyroid disorder
_____other

Gastrointestinal

_____nausea / vomiting
_____constipation
_____diarrhea
_____irritable bowel syndrome
_____GI bleeding
_____**hepatitis**
_____**NASH**
_____**cirrhosis**
_____**heartburn / GERD**
_____**swallowing difficulties**
_____peptic ulcers
_____Crohn's disease
_____gallstones
_____other

Musculoskeletal

_____osteoporosis
_____joint pain
_____back pain
_____arthritis
_____fibromyalgia
_____joint replacement
_____other

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

_____headaches
_____seizures
_____muscle weakness
_____pseudotumor cerebri
_____neuropathy
_____multiple sclerosis
_____other

Psychosocial

_____anxiety/nervousness
_____depression
_____eating disorder
_____bipolar disorder
_____psychosis
_____schizophrenia

Reproductive (female)

_____menstrual irregularities
_____**PCOS** (polycystic ovarian syndrome)

Other

_____anemia
_____**stress urinary incontinence**
_____cancer
_____kidney stones
_____trouble urinating
_____hearing problems
_____vision problems
_____HIV
_____Lupus
_____MRSA
_____other

SURGICAL HISTORY:

Date Hospital Surgeon

History of previous weight loss surgery? _____ Yes _____ No _____

What type? _____

What was your weight before the surgery? _____

What was your lowest weight after surgery? _____

Did you have complications? _____ Yes _____ 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? _____