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			

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

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

_____soda/soft drinks
_____steak/chops
_____chocolate
_____cream sauces/gravies
______French fries
______candy
______pasta
______salad dressings
______pizza
______fried foods
______cakes/pies
______ice cream
______chips/salty snacks
______potatoes
______cookies

How would you describe your exercise? _____ Never _____ Some Days _____ Most Days

What type of exercise do you enjoy?
____

What prevents you from exercising? ____

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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

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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? _____________________________________

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