



Weight Loss Surgery Center 2900 First Avenue Huntington, WV 25702
(304) 399-4903

Patient Name: _____ D.O.B. _____ Age: _____
Address: _____
Phone #: _____ Work #: _____
Who referred you to us? _____

Weight Related Data

Current Weight: _____ Height: _____

Previous Weight Reduction Data

Have you ever had surgery for weight loss? Yes No
Have you ever been seen in consultation about weight loss surgery? Yes No
If yes, please list surgeon's name, type of obesity surgery done, and date surgery was done.

Surgeon's Name	Type of Surgery/Consultation	Date of Surgery/Consultation

Past Medical History

List all medical conditions and hospitalizations. Please list names, addresses, and phone numbers of all your doctors (including your primary care physician, heart doctor, psychiatrist, therapist, or any other physician(s) you see on a regular basis).

Physician/Medical Condition	Address	Phone Number

Check those which apply:

Comments:

- Reflux Disease
- High Blood Pressure
- Degenerative Joint Disease
- Urinary Stress Incontinence
- High Cholesterol
- Venous Stasis (Leg Swelling)
- Irregular Menstrual Period
- Diabetes
- Do you use insulin? Yes No
- Sleep Apnea
- Do you C-pap? Yes No Bi-pap? Yes No

GASTRIC BYPASS PATIENT HISTORY FORM

SMMC: 53- 3
Adopted Date: 7/03
Revised Date: 12/03
Reviewed Date

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / *«PatientNumber»*
«SSN» / «Room» / «MedicalRecordNumber»

Family History

Is there a family history (mother, father, sister, brother) of any of the follow? If so, please list the relationship.

- Heart Disease _____
- Diabetes _____
- Cancer (type) _____
- High Blood Pressure _____
- Bleeding Disorder _____
- Other Family Disease _____

Age of Mother: _____

Age of Father: _____

NOTE: If deceased list the age at time of death and cause of death.

Review of Systems

Do you have any of the following? If yes, please explain.

GENERAL:

- Unplanned weight change _____
- Fevers _____
- Chills _____
- Sweats _____
- Loss of energy _____
- Fatigue _____

HEAD/EARS/EYES/NOSE/THROAT:

- Visual Problems _____
- Glasses/contacts _____
- Cataracts _____
- Hearing Problems _____
- Sore Throat _____
- Hoarseness _____
- Sinus Infection _____

PULMONARY:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you been told that you habitually snore or that you have pauses in breathing during sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is your sleep restless (awaken with bedcovers in disarray) or do you have excessive sweating during sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you ever awaken with shortness of breath, choking or gasping sensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you experience excessive sleepiness during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you taking more than one antihypertensive (blood pressure medication)? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cough _____ | | |
| <input type="checkbox"/> Sputum production _____ | | |
| <input type="checkbox"/> Wheezing _____ | | |
| <input type="checkbox"/> Shortness of breath _____ with exertion _____ without exertion | | |
| <input type="checkbox"/> Tuberculosis (TB), positive TB Test | | |
| <input type="checkbox"/> Coughing up blood _____ | | |
| <input type="checkbox"/> Use 2 or more pillows to sleep _____ | | |

GASTRIC BYPASS HISTORY FORM

Review of Systems (con't)

PULMONARY Con't:

- Tuberculosis (TB), positive TB Test _____
- Coughing up blood _____
- Use 2 or more pillows to sleep _____
- Snoring _____
- Wake up with a headache _____
- Fall asleep at the wheel _____
- Have to take a nap every day _____
- Do not feel rested when you wake up in the morning. _____
- Wake up from a deep sleep choking or coughing _____
- Have had a sleep study test _____
- Been told that you stop breathing while you are sleeping _____

CARDIAC:

- Chest pain with exertion (pain scale 1-10) _____
- Chest Pressure _____
- Irregular heart beat _____
- Palpitations _____
- Congestive Heart failure _____
- Rheumatic fever _____

GASTROINTESTINAL:

- Abdominal pain (pain scale 1-10) _____
- Trouble swallowing _____
- Nausea _____
- Vomiting _____
- Dark/black stool _____
- Yellow jaundice _____
- Diarrhea _____
- Constipation _____
- Bright Red blood in stool _____
- Hemorrhoids _____
- Stomach ulcers _____
- Heartburn or reflux If yes, how often does it happen? _____ less than once per week
If yes, how often does it happen? _____ less than once per week _____ 1-2 times a week
_____ 3-4 times a week _____ 5 or more times a week

GENITOURINARY:

- Blood in urine _____
- Hesitancy _____
- Decreased force of urination _____
- Discomfort with urination _____
- Kidney stones _____
- Frequent urination _____
- Recent urinary tract infection _____
- Prostate problems _____
- Leak urine when you cough, sneeze, or laugh _____
If yes, do you wear a pad for protection? _____

PAIN SCALE: 1-2 MILD 3-4 MODERATE 5-6 SEVERE 7-8 VERY SEVERE 9-10 WORST POSSIBLE PAIN

GASTRIC BYPASS HISTORY FORM

Patient Name: _____
Soc. Security No: _____

Review of Systems (con't)

HEMATOLOGIC:

- Abnormal bleeding _____
- Easy bruising _____
- Blood clots in legs or lungs _____
- Ever been diagnosed with HIV, AIDS, Hepatitis B, Hepatitis C _____
- Kidney stones _____

NEUROLOGICAL:

- Severe or chronic headache/migraine (pain scale 1-10) _____
- Dizziness _____
- Passing out _____
- Seizure/epilepsy _____
- Stroke _____
- Paralysis _____

MUSCULOSKELETAL:

- Joint pain/where (pain scale 1-10) _____
- Swelling in arms/legs _____
- Back pain/acute or chronic (pain scale 1-10) _____
- Pain in legs when walking (pain scale 1-10) _____
- Leg ulcers _____
- Varicose veins _____

PSYCHOLOGICAL:

- Depression _____
- Anxiety/nerve problems _____
- Ever received psychiatric/psychological treatment _____

GYNECOLOGIC:

- Breast pain (pain scale 1-10) _____
- Breast lumps _____
- Breast nipple discharge _____
- Menopause If yes, at what age _____
- Last menstrual cycle _____
- Irregular or abnormal menstrual cycle _____

Endocrine:

- High cholesterol or triglycerides _____
- Diabetes _____

Please list all diet programs you have done **in the past 5 years.**

Diet Program	When and How Long?	Total Weight Loss	Pounds Regained
Dietitian			
Physician Supervised			
Phen-Fen			
Redux			
Meridia			

PAIN SCALE: 1-2 MILD 3-4 MODERATE 5-6 SEVERE 7-8 VERY SEVERE 9-10 WORST POSSIBLE PAIN

GASTRIC BYPASS HISTORY FORM

Patient Name: _____
Soc. Security No: _____

