Bariatric Health History Form

Specialists in General Surgery
9825 Hospital Drive, #105
Maple Grove, MN 55369
763-780-6699 | www.sgsmn.com

Thank you for attending the Metabolic & Bariatric Surgery Informational Class! We are excited to help you on your journey toward improved health. Please complete the following steps to prepare for your consultation.

1. Call the member services phone number on the back of your insurance card and ask if you have a bariatric surgery benefit as part of your insurance plan. If you do not, you may call our office to discuss other options. **Specialists in General Surgery 763-780-6699.**

2. **We will check on your benefits and contact you** within a few days to schedule an appointment with Elizabeth Becker, APRN, CNP.

   Appointment date: _____Time: _____

   Location: _____

3. **Please bring the following to your consultation:**

   ☐ This completed form

   ☐ Your current medications in their bottles with labels attached

   ☐ Any lab work results in the last year.

   ☐ Your current insurance card and a photo ID

4. **Fill out this form completely prior to your appointment and bring it with you.** This is very important to your visit and is used to plan your care. Your appointment may be cancelled if this is not done.

5. **Please arrive 15 minutes prior to your scheduled appointment** to start your visit on time and get the most out of your time with us.

BARIATRIC HEALTH HISTORY FORM

Patient name: _____ DOB:_____

Primary health care provider name:_____

Clinic location & address: _____

Provider phone #:_____

Were you referred by this provider? ☐ Yes ☐ No

If not, how did you hear about the North Memorial Metabolic & Bariatric Surgery program?

_____

Please list all physicians/health care providers from whom you receive care. Include the provider's area of specialty, address, and phone numbers.

Physician Name: _____ Clinic: _____

Address: _____

Specialty:_____ Phone: _____

Physician Name: _____ Clinic: _____

Address: _____

Specialty:_____ Phone: _____

Physician Name: _____ Clinic: _____

Address: _____

Specialty:_____ Phone: _____

Physician Name: _____ Clinic: _____

Address: _____

Specialty:_____ Phone: _____

When was your last full physical exam and by whom?_____

WEIGHT HISTORY

1. Current Weight:_____
2. I have been at my current weight for_____ years.
3. My highest adult weight:_____
4. My average weight for the past 5 years:_____
5. My lowest adult weight was:_____at age:_____
6. Reasons for my weight gain: _____ .
7. My obesity started: ☐ In childhood ☐ Puberty ☐ As an adult ☐ After pregnancy ☐ Life event

WEIGHT LOSS & EXERCISE HISTORY

Be specific with the name, year, and number of months you used each weight loss method. Use additional sheets if necessary.

MEDICALLY SUPERVISED WEIGHT LOSS	YEAR	LENGTH OF TIME	WEIGHT LOST
WEIGHT LOSS PROGRAMS	**YEAR**	**LENGTH OF TIME**	**WEIGHT LOST**
DIETS	**YEAR**	**LENGTH OF TIME**	**WEIGHT LOST**

What helped you be successful with weight loss in the past? _____

In what areas do you struggle when trying to lose weight?_____

What do you think adds to your difficulty in losing weight? Check all that apply:

☐ Snacking ☐ Portion size ☐ Hungry all the time ☐ Poor food choices ☐ Poor meal planning
☐ Too busy to eat healthy ☐ Too busy to exercise ☐ Lack of support ☐ Tired all the time

Other: _____

CURRENT EXERCISE SCHEDULE:

EXERCISE TYPE (WALK, SWIM, JOG, ETC)	TIMES PER WEEK	MINUTES PER TIME

ABILITY TO WALK:

☐ No limitation

Assistive devices (check all that apply): ☐ Brace ☐ Cane ☐ Walker ☐ Wheelchair

How far can you walk without stopping? _____

What activities do you enjoy that keep you active? _____

Do you have restrictions that keep you from exercising?_____

Are there activities you cannot participate in currently or hope to do in the future?_____

_____

CURRENT EATING HABITS

	YES	NO	COMMENT
Do you eat 3 meals a day?			
Do you skip meals?			
Do you snack?			

Where do you eat your meals?

Breakfast: _____

Lunch: _____

Dinner: _____

Where and when do you eat at work? _____

What do you eat for a typical meal? (Please provide several examples)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many times a week do you eat out? _____ Where? _____

Who prepares the meals in your home? _____

Do you have any food intolerances? _____

Do you have any dietary restrictions? _____

DAILY LIQUIDS	MILK	JUICE	WATER	OTHER (DESCRIBE)	
Ounces per day					
CAFFEINE USE	**COFFEE**			**SODA (REG/DIET?)**	**OTHER**
Ounces per day					

EATING HABITS:

Check all that apply: ☐ Binge eating ☐ Stress eating ☐ Emotional eating ☐ Nighttime eating

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

If yes, provide details: _____

_____

_____

MEDICATIONS

List all current medications, vitamins, over-the-counter medications, supplements. Include any medications you only take occasionally.

NAME	STRENGTH	HOW MANY PILLS DO YOU TAKE?	WHEN DO YOU TAKE THIS MEDICINE?	WHY DO YOU TAKE THIS MEDICINE?

ALLERGIES

Please list allergies to medicine, food, dye, tape, metal, latex, environment, etc.

ALLERGIC TO:	WHAT HAPPENS WHEN YOU TAKE IT OR ARE EXPOSED TO IT?

PAST MEDICAL HISTORY, MEDICAL CONDITIONS, OR HOSPITALIZATIONS

ILLNESS, INJURY OR HOSPITALIZATIONS	DATE	TREATMENT

If you have ever been diagnosed with cancer:

Type:_____

Treatment: _____

Dates: _____

How long has it been since your last cancer treatment?_____

PREVIOUS SURGERY – LIST ALL PREVIOUS SURGERIES

SURGERY	YEAR	INCISION LOCATION	REASON

Have you had problems with anesthesia? ☐ Yes ☐ No Comment: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Comment: _____

Have you had any surgical complications? ☐ Yes ☐ No Comment: _____

Have you had wound infection/healing issues? ☐ Yes ☐ No Comment: _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH:	YES	NO	COMMENT/ FAMILY MEMBER
Bleeding or clotting disorder?			
Stomach cancer or intestinal cancer?			
Sudden or early (under age of 50) cardiac disease or death?			
Reaction to anesthesia?			
Stroke?			
Diabetes?			
Lung Disease?			
Other Cancer?			

SOCIAL HISTORY

Are you currently employed? ☐ Yes ☐ No Occupation? _____

Are you disabled? ☐ Yes ☐ No Reason: _____

Work Status: _____

Are you presently married? ☐ Yes ☐ No If yes, for how long? _____

Are you in a long-term relationship or have a significant other? ☐ Yes ☐ No How long? _____

Is your relationship stable? ☐ Yes ☐ No Explain: _____

Do you have any children? ☐ Yes ☐ No What are their ages? _____

Whom do you live with? _____

Whom can you rely on for support when you need it? _____

Are you going through any major life changes or stressors now or in the next year? ☐ Yes ☐ No

(divorce, moving, school, etc) _____

Tobacco use? (Any use of cigarettes, chewing tobacco, e-cigarettes, pipe, cigar, marijuana):

☐ Currently using Type: _____

☐ History of Packs per Day: _____

☐ Never used Number of Years: _____

Quit date: _____

Alcohol use? ☐ Yes ☐ No

How many days a week do you have drinks containing alcohol?_____

How many drinks per day?_____Type: _____

Have you ever had treatment for alcohol or drug use? ☐ Yes ☐ No Dates:_____

Have you ever been told you should undergo treatment for alcohol or drug use? ☐ Yes ☐ No

Any other current or past drug or substance use? ☐ Yes ☐ No

If yes, details: _____

Highest level of education completed? _____

Do you have barriers to learning? ☐ Yes ☐ No Describe:_____

Rate your overall satisfaction with yourself: (1 is least satisfied – 5 is most satisfied)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Explain your answer: _____

DENTAL PROBLEMS

	YES	NO	COMMENT
Do you have dentures or partials?			
Ever been diagnosed with TMJ disorder?			
Do you have trouble chewing?			
Do you have trouble swallowing?			
Do you have missing teeth?			
When was your last dental visit?	Date?		
Do you need dental work done?			

ENDOCRINE

	YES	NO	COMMENT
Do you have thyroid problems?			
Are you diabetic? ☐ Type I ☐ type II			Date diagnosed:
Do you have a history of pancreatitis?			If yes explain:

When was your last thyroid test (TSH) _____ and what was the result?_____

What was your last HbA1c result? _____

Notes on diabetes: _____

_____

RESPIRATORY/SLEEP HISTORY

	CURRENTLY	IN THE PAST, BUT NOT CURRENTLY	NO HISTORY
Shortness of breath with activity?			
Do you have emphysema or COPD?			
Do you have asthma?			
Do you use oxygen?			

Where do you sleep? (Bed, recliner, etc.) _____

How many hours of sleep do you get in a typical night? _____

CARDIOVASCULAR

	YES	NO	COMMENT
Do you have heart disease?			
Current or past heart problems?			
Have you had an EKG?			
Have you had an echocardiogram?			
Have you had a stress test?			
Have you had any other heart tests?			
Do you have high blood pressure?			
Do you have high cholesterol?			
Have you ever had blood clots in your legs?			
Have you ever had blood clots in your lungs?			

GASTROINTESTINAL

	YES	NO	COMMENT
Do you have heartburn?			How frequently?
Do you ever have breakthrough heartburn when you're taking medication for heartburn?			
Do you wake at night with acid reflux?			
Have you ever been diagnosed with an ulcer?			
Have you ever been diagnosed with H. pylori?			
Do you have gastroparesis (slow emptying stomach)?			
Have you been diagnosed with colitis?			
Have you been diagnosed with spastic colon?			
Have you been diagnosed with irritable bowel?			
Have you been diagnosed with Crohn's disease?			
Have you had a colonoscopy in the past?			When:
Have you had an upper endoscopy (EGD)?			When:
Have you had any change in bowel habits or blood in stool?			
Do you have abdominal pain?			
Do you have frequent or recurring nausea?			
Do you have gallstones/gallbladder disease?			
Have you ever had Clostridium Difficle? (C Diff)			

BLOOD DISORDERS/INFECTIOUS DISEASES

	YES	NO	COMMENT
Have you ever had anemia (low hemoglobin)?			When:
Have you ever had a blood transfusion?			
Do you bleed/bruise easily?			
Do you have HIV?			
Do you have cirrhosis or liver disease?			
Have you ever had hepatitis?			Type?

KIDNEYS/GENITOURINARY

	YES	NO	COMMENT
Do you have kidney problems?			
Have you ever had kidney stones?			When:
Do you ever involuntarily lose your urine?			

REPRODUCTIVE (Women Only)

	YES	NO	COMMENT
Do you use birth control?			Type:
Do you want to be pregnant in the future?			
Have you gone through menopause?			
Do you have a history of polycystic ovarian syndrome (PCOS)?			

TEST	DATE/COMMENT
When was your last Pap test and pelvic exam?	
Do you have any breast masses that have not been evaluated?	
When was your last mammogram?	

MENSTRUAL PERIODS: (Women Only)

Date of last menstrual period: _____

Check all that apply:

☐ Regular ☐ Irregular ☐ Not Applicable ☐ Heavy Flow ☐ Normal Flow ☐ Flow contains many clots

MUSCLE, BONE AND JOINT PROBLEMS

	YES	NO	COMMENT
Do you have degenerative arthritis?			Which joints?
Do you have inflammatory/rheumatoid arthritis?			
Do you have fibromyalgia?			
Have you ever had gout?			

	ANKLES	KNEES	HIPS	BACK	FEET	NECK	OTHER
Swelling							
Pain							
Stiffness							
Diagnosed arthritis							
Joint replacement							

SKIN

	YES	NO	COMMENT
Do you have a history of MRSA/VRE infection?			
Do you have a history of wound healing problems?			
Do you have a history of cellulitis?			
Do you have a history of skin cancer?			
Do you have any skin breakdown or hygiene difficulties?			

NEUROLOGICAL PROBLEMS

HAVE YOU EVER BEEN DIAGNOSED WITH:	YES	NO	COMMENT
Seizures			
Stroke/TIA			
Neuropathy			
Sciatica			
Pseudo tumor			
Narcolepsy			
Paralysis			
Restless legs			
Migraines			
Multiple sclerosis			
Charcot-Marie-Tooth syndrome			
Other			

PSYCHIATRIC HISTORY

	YES	NO	COMMENT
Have you ever had psychiatric treatment?			
Have you been hospitalized for psychiatric care?			
Are you currently experiencing depression or anxiety?			
Have you been the victim of child abuse?			
Have you been the victim of sexual abuse?			

We at Specialists in General Surgery are concerned about violence that can impact the health of many of our patients, so we routinely ask everyone the following confidential questions:

1. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?

☐ Yes ☐ No

If yes, who was doing this? _____

2. Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?

☐ Yes ☐ No

If yes, who was doing this? _____

If you answered "yes" to the questions above about abuse, was the abuse (check all that apply):

☐ Verbal ☐ Physical ☐ Sexual

If you answered "yes" to the questions above, were you treated by a (check all that apply):

☐ Psychologist ☐ Therapist ☐ Psychiatrist ☐ Physician

When was your treatment? _____

How long have you been in or were you in treatment?_____

Diagnosis and reason for treatment: _____

_____

_____

_____

_____

If you currently see a therapist, for any reason, please list the name of the provider and nature of your visits:

Name: _____

Phone: _____

How long have you been seeing this provider? _____

How often do you visit with him or her?_____

What are you being treated for?_____

_____

_____

_____

_____

This section is required to be filled out prior to your appointment:

WHY do you want to have weight loss surgery? We want to know what motivated you to come in now, at this time in your life.

What are your goals and expectations? (Health goals, activity goals, or other things you cannot currently do that you hope to do after surgery)

Include any physical and/or emotional benefits you hope to experience from weight loss.

PERMISSION TO USE PHOTOGRAPH AND LIKENESS

I hereby grant North Memorial Health and Specialists in General Surgery, their successors and assigns, the right to use and publish for medical purposes, as a demonstration to prospective patients or physicians and medical personnel associated with the American Society for Metabolic and Bariatric Surgery and at similar meetings of physicians and medical personnel, for advertising purposes, for educational purpose, or in any other way which they deem tasteful and appropriate, photographic portraits or photographic likenesses or pictures of me, pre-operatively and post-operatively, along with a description of the health problems involved.

I waive any right that I may have to inspect or approve the finished product or the advertising or other copy that may be used in connection therewith or the use to which it may be applied.

I release and discharge the photographer, North Memorial Health, Specialists in General Surgery, their successors and assigns and all persons acting under their permission or authority, from any liability that may occur or be produced in the taking of the pictures, or the use thereof.

The undersigned has entered into this agreement as a demonstration to assist prospective patients, physicians, medical personnel, and/or public relations and hereby waives any right to compensation for these uses.

The term "photograph" as used in this agreement shall mean motion picture or still photography in any format, as well as videotape, videodisc, and any other mechanical means of recording and reproducing images. This consent may be withdrawn at any time.

Patient Photo Album ☐ Yes ☐ No

Website ☐ Yes ☐ No

Newspaper/Magazine ☐ Yes ☐ No

Patient Signature: _____ Date: _____

I give permission to include information regarding my surgical outcomes in the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program database. No personal or identifying information is entered into the database as part of this data collection. It is used for purposes of program outcomes and comparison to other programs nationally.

Patient Signature: _____ Date: _____