Bariatric Health History Form

Specialists in General Surgery
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Thank you for your interest in our Bariatric and Metabolic Weight Loss surgery program. We are excited to help you on your journey toward improved health. Please allow 30-60 minutes to complete the form depending on your medical history. This is very important to your visit and is used to plan your care.

Patient Name: DOB:

Were you referred by a medical provider? ○ Yes ○ No

If **YES**, Medical provider name & clinic:

If **NO**, how did you hear about the North Memorial Metabolic & Bariatric Surgery program?

Please list all physicians/healthcare providers from whom you receive care. Include each provider's name, area of specialty, clinic name, and phone number.

Weight and Exercise History:

1. When did your obesity start? ☐ In childhood ☐ Puberty ☐ As an adult
2. I have been at my current weight for ____ years.
3. My highest adult weight(lbs.):
4. My average weight for the past 5 years (lbs.):
5. My lowest adult weight was: at age:
6. My obesity was worsened by: ☐ Pregnancy ☐ Medications ☐ Injury ☐ A life event
7. Please list previous weight loss attempts (example: Weight Watchers, 3 months, lost 10 pounds).
8. What do you think makes it more difficult to lose 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

9. List current exercise types (walk, swim, weights, etc.), how many days per week, and how many minutes spent on each exercise?

Exercise Type	# days per week	# of minutes

10. Do you have restrictions that keep you from exercising? ☐ No ☐ Yes
11. How far can you walk without stopping? _____
12. If you use an assistive device(s), check all that apply: ☐ Brace ☐ Cane ☐ Walker ☐ Wheelchair

Current Eating Habits:

1. Do you eat 3 meals a day? ☐ No ☐ Yes
2. I skip meals _____ days/week.
3. How many times a day do you snack? _____
4. Where do you regularly eat your meals? ☐ At the table ☐ On the couch ☐ At my desk ☐ In my car ☐ Other
5. Can you have water at your workplace? ☐ Yes ☐ No ☐ N/A
6. What does your typical breakfast consist of? (Provide several examples)
7. What does your typical lunch consist of? (Provide several examples)
8. What does your typical dinner consist of? (Provide several examples)
9. What do your typical snacks consist of? (Provide several examples)
10. How many times a week do you eat out? _____
11. When you eat out, where do you go? _____
12. Who prepares the meals in your home? _____
13. Do you have any food intolerances, allergies, or dietary restrictions? ☐ Yes ☐ No

    If **YES**, list any food intolerances, allergies, or dietary restrictions: _____

14. I drink _____ oz of water a day.
15. I drink _____ oz of milk a day.
16. I drink _____ oz of juice a day.
17. I drink _____ oz of soda (reg/diet) a day.
18. I drink _____ oz of coffee a day.
19. Have you ever made yourself vomit to control your weight? ☐ Yes ☐ No
20. Do you ever hide your eating habits from others? ☐ Yes ☐ No
21. Do you feel loss of control when you are eating? ☐ Yes ☐ No
22. Do you have any of the following eating habits? (Check all that apply)
    ☐ Stress eating ☐ Emotional eating ☐ Nighttime eating ☐ None
23. Have you ever been treated for an eating disorder? ☐ Yes ☐ No
24. If **YES**, which eating disorder? ☐ Binge eating ☐ Anorexia ☐ Bulimia ☐ Other

Dental History:

1. Do you have any of the following dental problems? (Check all that apply)
   ☐ Dentures or partials ☐ Diagnosed with TMJ disorder ☐ Trouble chewing
   ☐ Trouble swallowing ☐ Missing Teeth ☐ None
2. If you are missing any teeth, how many? _____
3. When was your last dental visit? _____
4. What dental work, if any, do you need done? _____

Endocrine History:

1. Do you have thyroid problems? ☐ Yes ☐ No
2. Are you diabetic? ☐ Yes, Type I date diagnosed: _____ ☐ Yes, Type II date diagnosed: _____
   ☐ No
3. Do you have a history of pancreatitis? ☐ Yes ☐ No If **YES,** explain: _____

Respiratory/Sleep History:

1. Do you have emphysema or COPD? ☐ Yes ☐ No
2. Do you have asthma? ☐ Currently ☐ In the past, but not currently ☐ No history
3. Do you use oxygen? ☐ Currently ☐ In the past, but not currently ☐ No history
4. Where do you sleep? (Bed, couch, recliner, etc.) _____
5. How many hours of sleep do you get in a typical night? _____
6. Have you ever had a sleep study? ☐ Yes ☐ No
7. Do you have sleep apnea? ☐ Yes ☐ No ☐ Unsure
8. Do you use a CPAP or BiPAP for sleep apnea? ☐ Yes ☐ No ☐ N/A
9. Do you experience any of the following? (Check all that apply) ☐ Loud Snoring ☐ Waking gasping for breath
   ☐ Stop breathing in sleep ☐ Daytime fatigue ☐ None

Cardiovascular History (check if you have any of the following):

☐ Heart Disease ☐ Current or past heart problems ☐ Had an echocardiogram ☐ Had a stress test
☐ Had other heart tests ☐ High blood pressure ☐ High cholesterol ☐ Blood clots in your legs
☐ Blood clots in your lungs ☐ None

Gastrointestinal History:

1. Check if you have any of the following:
   ☐ Heartburn ☐ Breakthrough heartburn when taking heartburn medication
   ☐ Wake at night with acid reflux ☐ Diagnosed with an ulcer ☐ Diagnosed with H. Pylori
   ☐ Gastroparesis (slow emptying stomach) ☐ Diagnosed with colitis ☐ Diagnosed with spastic colon
   ☐ Diagnosed with irritable bowel ☐ Diagnosed with Crohn's disease
   ☐ Change in bowel habits or blood in stool ☐ Abdominal pain
   ☐ Frequent or recurring nausea ☐ Gallstones/gallbladder disease ☐ Clostridium Difficile (C. Diff)
   ☐ None
2. How frequently do you have heartburn/reflux?
3. How often do you have a bowel movement/stool?
4. When was your last colonoscopy?
5. When was your last upper endoscopy (EGD)?

Blood Disorders/Infectious Diseases History (check if you have any of the following):

☐ Anemia (Low hemoglobin) ☐ Blood transfusion ☐ Bleed/bruise easily ☐ HIV ☐ Cirrhosis or liver disease
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ History of surgical complications ☐ None

Kidney/Genitourinary History (check if you have any of the following):

☐ Kidney problems ☐ Kidney stones ☐ Involuntarily lose your urine ☐ None

Reproductive Health History (Women):

1. Birth Control Method (Check all that apply):
   ☐ Birth Control Pill ☐ Implant IUD ☐ Birth Control Shot (Depo-Provera) ☐ Birth Control Vaginal Ring
   ☐ Birth Control Patch ☐ Take medication with Estrogen ☐ Breastfeeding
   ☐ Want to be pregnant in the future ☐ History of polycystic ovarian syndrome (PCOS)
   ☐ None
2. Date of last Pap test and pelvic exam?
3. Date of last mammogram?

4. Date of last menstrual period?

5. Menstrual Periods (Check all that apply):
   ☐ Regular ☐ Irregular ☐ Heavy Flow ☐ Normal Flow ☐ Flow contains many clots ☐ Menopause
   ☐ N/A

Muscle/Bone/Joint Problems History (check if you have any of the following):

☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Gout ☐ Osteoarthritis
☐ Chronic joint pain ☐ None

Skin History (check if you have any of the following):

☐ History of MRSA/VRE infection ☐ History of wound healing problems ☐ History of cellulitis
☐ History of skin cancer ☐ Skin breakdown or hygiene difficulties ☐ None

Neurological Problems History (check if you have any of the following):

☐ Seizures ☐ Stroke/TIA ☐ Neuropathy ☐ Pseudo tumor cerebri ☐ Narcolepsy ☐ Paralysis ☐ Restless legs
☐ Migraines ☐ Multiple sclerosis ☐ None

Psychiatric History:

1. Have you ever had psychiatric treatment? ☐ Yes ☐ No
2. Have you been hospitalized for psychiatric care? ☐ Yes ☐ No
   - If **YES**, please provide details:
3. Are you currently experiencing depression? ☐ Yes ☐ No
4. Are you currently experiencing anxiety? ☐ Yes ☐ No
5. Are you currently under the care of a mental health care provider such as a therapist, counselor, psychiatrist, etc. for the treatment of health conditions such as depression, anxiety, bipolar, schizophrenia, or other conditions? ☐ Yes ☐ No
   - If **YES**, please explain by listing the name of the provider and phone number, how long you have been seeing them, how often are the visits, and reason for treatment).
6. Have you had any mental health crisis or evaluation for thoughts of self-harm or harm to others requiring an ER visit in the last year? ☐ Yes ☐ No

Social History:

1. Employment Status:
   ☐ Full-time ☐ Part-time ☐ Overnights ☐ Retired ☐ Unemployed

2. What is your occupation?
3. Are you disabled? ☐ Yes ☐ No
    - Reason for disability:
4. Are you presently married? ☐ Yes ☐ No
    - If **YES**, for how long?
5. Is your relationship stable/supportive? ☐ Yes ☐ No ☐ N/A
6. Do you have any children? ☐ Yes ☐ No
    - If **YES**, what are their ages?
7. Whom do you live with?
8. Whom can you rely on for support when you need it?
9. Are you going through any major life changes or stressors now or in the next year? (ex. moving, divorce, marriage, new job, school, etc.) ☐ Yes ☐ No
    - If **YES**, explain:
10. Highest level of education completed?

    ☐ Did not complete high school ☐ High school diploma ☐ High school equivalency

    ☐ Some college but no degree ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree

    ☐ Doctoral degree
11. Do you have barriers to learning? ☐ Yes ☐ No
    - If **YES**, describe:
12. Smoking/Nicotine Use (select all that apply):

    ☐ Currently using cigarettes ☐ Currently using e-cigarettes ☐ Currently using vape

    ☐ Currently using chewing tobacco ☐ Currently using pipe ☐ Currently using cigar

    ☐ Currently using marijuana/weed ☐ History of cigarette use ☐ History of e-cigarette use

    ☐ History of vaping ☐ History of chewing tobacco ☐ History of pipe use ☐ History of cigar use

    ☐ History of marjuana/weed use ☐ Never used
    - If currently using, how much per day and how many years have you been using for?
    - If history of using, when did you quit?
13. How many days a week do you drink alcohol?
    - How many alcoholic beverages per day do you drink?
    - What type of alcohol do you drink? ☐ Wine ☐ Beer ☐ Hard Liquor ☐ None
    - Has anyone expressed concerns about your drinking habits? ☐ Yes ☐ No
    - Have you ever had treatment for alcohol or drug use? ☐ Yes ☐ No
        - Dates received treatment:
    - Have you ever been told you should undergo treatment for alcohol or drug use? ☐ Yes ☐ No

- If **YES**, details:

Motivations/Goals/Expectations:

1. 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.

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

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

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. Are you currently in a safe living situation? ☐ Yes ☐ No
2. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone in your life? ☐ Yes ☐ No
   - If **YES**, who was doing this and when?
3. 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?
4. If you answered **YES** to the questions above about abuse, was the abuse (check all that apply)
   ☐ Verbal ☐ Physical ☐ Sexual

I certify that the information provided on this form is accurate. I understand that my answers are used to guide my providers in medical decision making. 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.

Signature: **Date:**