

Office Use Only	
Date: _____	BMI: _____
Candidate for Surgery: YES	
NO	

Health History

Patient Information	<p>Patient Name: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>Date of Birth: _____ Current Age: _____ Height: ____ Feet ____ Inches</p> <p>Current Weight: _____ lbs. Highest weight: _____ lbs (when) _____</p> <p>Weight at age 18: _____</p> <p>Ethnicity: (Check all that Apply) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other</p> <p>I am interested in: <input type="checkbox"/> Adjustable Gastric Band <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Sleeve Gastrectomy <input type="checkbox"/> Revision of previous bariatric surgery <input type="checkbox"/> Unsure</p> <p>Occupation: _____</p> <p><input type="checkbox"/> Full-time (>35 hours) <input type="checkbox"/> Part-time (<35 hours) <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Self-employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student</p>
Social History	<p>Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Life Partner</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Do you have children? If yes, how many do you have? _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Do you have grandchildren? If yes, how many do you have? _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used tobacco products? Is yes, did you use (check all that apply): <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing tobacco</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Do you <i>currently</i> use tobacco products?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used illegal or street drugs? If yes, did you use illegal drugs? <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently Have you stopped using street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink alcohol? If yes, do you drink? <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had an addiction problem that required treatment or rehab? If yes, please check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal (street) drugs <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Other addiction(s): _____</p>
Family History	<p>Father's present age: _____ OR age at death: _____ Cause of death: _____</p> <p>Health problems: _____</p> <p>Mother's present age: _____ OR age at death: _____ Cause of death: _____</p> <p>Health problems: _____</p> <p>How many brothers and sisters do you have in your family? _____</p> <p>Please check the box(s) if there is a family history of:</p> <p><input type="checkbox"/> Obesity <input type="checkbox"/> Heart disease <input type="checkbox"/> Blood clotting or bleeding disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Lung disease, asthma, emphysema <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Gastric cancer</p>

<p>Endocrine</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been told that you are pre-diabetic or have high blood sugars?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you currently have diabetes?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take insulin?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take oral diabetic medication?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use diet only to treat your diabetes?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take medication for thyroid disease?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever used steroids for any medical problem(s) in the past year?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with sickle cell disease or trait?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you HIV positive or do you AIDS?</p>
<p>Pulmonary (Lungs)</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been under the care of a lung specialist (pulmonologist) in the last 2 years?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you get short of breath walking up a flight of steps?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you get short of breath walking a city block?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have a history of bronchitis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have asthma? If yes:</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you inhale daily?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use inhalers only when needed?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use nebulizer treatments?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use oxygen?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been hospitalized for asthma within the last 2 years?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Is your asthma well controlled?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with sleep apnea? If yes:</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use an oral appliance?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use a CPAP machine?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use a Bipap machine?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use nighttime oxygen?</p> <p style="padding-left: 20px;"><input type="checkbox"/>Yes <input type="checkbox"/>No Have you had surgery for the treatment of sleep apnea?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you snore when you sleep?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you wake up at night trying to catch your breath?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you wake up frequently with a headache?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you wake up from your sleep to urinate nightly?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you routinely sleep in a recliner chair at night?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have a chronic cough?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with tuberculosis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with COPD?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with emphysema?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with sarcoidosis?</p>
<p>Cardiac</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been under the care of a heart specialist (cardiologist) in the last 5 years?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have high blood pressure?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take medication for high blood pressure?</p>

	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you seen a doctor for irregular heartbeats?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take medication for irregular heartbeats?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been told that you have a heart murmur?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been told that you have mitral valve prolapsed?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you currently have chest pain(angina)? If yes, do you have chest pain: <input type="checkbox"/>While sitting still? <input type="checkbox"/>While walking? <input type="checkbox"/>With strenuous work/exercise</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a heart attack?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had an abnormal EKG (heart tracing)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a cardiac (heart) catheterization?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a heart treadmill or chemical stress test?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been told that you have congestive heart failure?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been hospitalized for heart failure?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had an angioplasty or cardiac stents placed for your heart disease? <input type="checkbox"/>Yes <input type="checkbox"/>No Are you on blood thinner medication for treatment of your heart disease?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have leg, ankle, or feet swelling?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you on medication for leg, ankle, or feet swelling?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had blood clots in your legs (DVT)? <input type="checkbox"/>Yes <input type="checkbox"/>No Were you treated with blood thinners?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had blood clots in your lungs (pulmonary embolus)? <input type="checkbox"/>Yes <input type="checkbox"/>No Were you treated with blood thinners?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been treated for leg, ankle, or foot ulcers (venous status ulcers)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have varicose veins? If yes, please circle: Right Leg Left leg Both</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had an IVC filter placed for blood clots?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a stroke?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been told that your cholesterol level was high?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take medication for high cholesterol levels?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been told that you have high triglyceride levels?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take medication for high triglyceride levels?</p>
<p>GI (Stomach/Intestines)</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you seen a GI specialist (gastroenterologist) in the past 2 years?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have frequent difficulty chewing or swallowing?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you suffer from difficulty having bowel movements (constipation)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use stool softeners routinely?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have frequent loose stools (diarrhea)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use anti-diarrhea medication routinely?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you or have you had hemorrhoids?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you suffer from heartburn (acid reflux)?</p>

	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you routinely take over the counter medications for heartburn?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you take prescription medications for heartburn (GERD)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been told that you have a hiatal hernia? (hernia In diaphragm).</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a stomach or duodenal ulcer?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with irritable bowel syndrome?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you lactose intolerant?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with Crohn’s disease?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with ulcerative colitis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with cirrhosis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with a fatty liver?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with hepatitis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with celiac sprue?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been treated for pancreatitis?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a previous weight-loss surgery?</p>
<p>HEENT/NEURO (HEAD)</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have frequent headaches or migraines?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you suffer from hearing loss? Circle: Right Left Both</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you wear glasses, contacts, or use reading glasses?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you suffer from chronic balance problems (vertigo)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a seizure?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently taking any medications to prevent seizures?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with multiple sclerosis (MS)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with pseudotumor cerebri? If yes,</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have nausea and dizziness with headaches?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have vision problems when you have your headaches?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had an MRI to confirm pseudotumor cerebri?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use diuretics for treatment of your pseudotumor cerebri?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you require narcotic medications for pseudotumor cerebri?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Has surgical treatment been recommended for you? If yes, have you received surgical treatment? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>Bones/Joints/Muscles</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with arthritis? If yes, which one- <input type="checkbox"/>Rheumatoid arthritis <input type="checkbox"/>Osteoarthritis <input type="checkbox"/>Degenerative joint disease <input type="checkbox"/>Other arthritis not listed above</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have hip pain that limits your activity level? Circle: Right Left Both</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have knee pain that limits your activity level? Circle: Right Left Both</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have ankles pain that limits your activity level? Circle: Right Left Both</p>

	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have shoulder pain that limits your activity level? Circle: Right Left Both</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have frequent back pain which limits your activity level?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with gout? If yes: <input type="checkbox"/>Yes <input type="checkbox"/>No Do you currently take medication(s) for gout?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use a cane or walker to help you walk? Circle- Sometimes Always</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you use a motorized scooter or wheelchair? Circle- Sometimes Always</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with a herniated disc(s)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been told that you have carpal tunnel disease?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with scleroderma?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with fibromyalgia? If yes, how is it treated: <input type="checkbox"/>Exercise <input type="checkbox"/>Surgical intervention done or recommended <input type="checkbox"/>Non-narcotic medications <input type="checkbox"/>Disabling- no treatment has been effective</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with lupus?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently under the care of an orthopedic surgeon or neurosurgeon?</p>
Cancer	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with a cancer other than skin cancer? If yes, what kind of cancer: _____</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have a clotting/bleeding disorder?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you had a DVT (deep vein thrombosis)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a blood clot in your lung (pulmonary embolism)?</p>
Bladder/Kidney	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have to urinate frequently?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have pain with urination?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have blood in your urine?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been told that you have protein in your urine?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a kidney stone?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have leakage of urine with laughing/coughing/sneezing? If yes: <input type="checkbox"/> Occurs less than once per wee <input type="checkbox"/> Greater than one occurrence per week <input type="checkbox"/> Occurs daily <input type="checkbox"/> Is disabling</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have leaking of stool(feces) with laughing/coughing/sneezing?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a bladder infection (UTI)?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a kidney infection?</p>
Psychological	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with depression? If yes, <input type="checkbox"/>Yes <input type="checkbox"/>No Do you require medications for your depression? <input type="checkbox"/>Yes <input type="checkbox"/>No Is your depression occasional or episodic? <input type="checkbox"/>Yes <input type="checkbox"/>No Does your depression prevent you from caring for yourself?</p>

	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Does your depression prevent you from keeping a job?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever required hospitalization for depression?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your depression?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Is your depression being treated by your family doctor?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with anxiety/panic attacks? If yes,</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you require medications for anxiety?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Is your depression only occasional or episodic?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Does your anxiety prevent you from maintaining employment?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever required hospitalization for anxiety?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your anxiety?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Is your anxiety being treated by your family doctor?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with having a bipolar disorder? If yes,</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you require medications for your bipolar disorder?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Does your bipolar disorder prevent you from caring for yourself?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Does your bipolar disorder prevent you from keeping a job?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever required hospitalization for bipolar disorder?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your bipolar disorder?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Is your bipolar disorder being treated by your family doctor?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever been diagnosed with schizophrenia or any other form of personality disorder or mental illness?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you been hospitalized for any form of mental illness or breakdown?</p>
<p>Gyn (For Women Only)</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Have you ever had a fertility workup?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you currently pregnant?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have monthly periods?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are your periods irregular?</p>

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have abnormality heavy or prolonged menstrual periods?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been pregnant? If so, during any pregnancy, did you have:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Low iron levels
<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-eclampsia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently going through or in menopause?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently using oral contraceptives?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently using any other form of contraception?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been diagnosed with polycystic ovarian disease (PCOS)? If yes:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you being treated with oral contraceptives?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you being treated with metformin?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you being treated with any other medication(s)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been told that you are infertile?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a Pap test done in the last two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an ectopic pregnancy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you receive a gynecological exam yearly?

Allergies	<p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you allergic to any medications? If yes please list any adverse Reaction—such as hives, rash, shortness of breath, or anaphylaxis:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Do you have a latex allergy?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No Are you allergic to shellfish, iodine, or contrast dye?</p>
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Sleep Apnea Evaluation:

- Sleep apnea is a disorder of breathing during sleep. Apnea during sleep consists of brief periods throughout the night in which breathing stops and is typically associated with loud snoring. People with sleep apnea do not get enough oxygen during sleep, and those who are morbidly obese are at a higher risk for this disorder.

Do you have Sleep Apnea? _____ Yes _____ No

If yes, do you wear a CPAP or Bipap machine at night? _____ Yes _____ No

If you have never been diagnosed with sleep apnea, please answer the questions below.
It is important to ensure we diagnosis this condition before your surgery.

1. Have you ever fallen asleep at work? _____ Yes _____ No
2. Do you snore? _____ Yes _____ No
3. Has anyone ever told you that stopped breathing at night? _____ Yes _____ No
4. Do you wake up at night? _____ Yes _____ No
5. If yes, do you notice that you gasp for breath or feel as if you are smothering? _____ Yes _____ No
6. Do you awaken at night with any chest discomfort or tightness? _____ Yes _____ No

Using the scale below, choose the best number to rate each situation and your chance of dozing off during these situations.

Scale:

0=would never doze

1=slight change of dozing

2=moderate chance of dozing

3=high chance of dozing

Situation:

Chance of dozing:

Sitting and reading

Watching TV

Sitting inactive in a public place (theater, meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total: _____

0-10: Normal Range 10-12: Borderline 12-24: Abnormal



WVU Bariatrics- A Comprehensive Surgical Weight Loss Program

Insurance Information

Primary Insurance Name: _____

Subscriber's Name: _____ Sex: ___ Male ___ Female DOB: _____

Subscriber's Address: _____ Phone: _____

Insurance ID #: _____ Group #: _____ Effective Date: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Name: _____

Subscriber's Name: _____ Sex: ___ Male ___ Female DOB: _____

Subscriber's Address: _____ Phone: _____

Insurance ID #: _____ Group #: _____ Effective Date: _____

Relationship to Patient: _____ Employer: _____
