WVU Medicine

WVU Bariatrics: A Comprehensive Surgical Weight Loss Program

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

Health History

Patient Information	Patient Name**: _____**□ Female □ Male Date of Birth: _____ Current Age: _____ **Height: ____Feet ____Inches** **Current Weight: _____lbs.** Highest weight: _____lbs (when) _____ Weight at age 18: _____Highest Level of Education: _____ Ethnicity: (Check all that Apply) □White/Caucasian □African-American □Hispanic □Asian □Native American or Alaska Native □Native Hawaiian □Pacific Islander □Other I am interested in: □Adjustable Gastric Band □ Gastric Bypass □Sleeve Gastrectomy □Revision of previous bariatric surgery □Unsure Occupation: _____ **Email:_____** □Full-time (>35 hours) □Part-time (<35 hours) □Unemployed □Daylight(7-3) □Evening(3-11) □Night Shift (11-7) □Disabled □Retired □Self-employed □Homemaker □Student
Social History	Marital status: □Single □Married □Divorced □Separated □Widow □Life Partner Who lives in the home with you? _____ □Yes □No Do you have children? If yes, how many do you have? _____ □Yes □No Have you ever used tobacco products? Is yes, did you use (check all that apply): □Cigarettes □Cigars □Pipe □Chewing tobacco □Vaping □Quit date:_____ /Packs/Pouches per day:_____ □Yes □No Do you *currently* use tobacco products? □Yes □No Have you ever used illegal or street drugs? □Marjiuana □Other If yes, did you use illegal drugs? □Rarely □Occasionally □Frequently Have you stopped using street drugs? □Yes □No Quit Date:_____ □Yes □No Do you drink alcohol? If yes, How often do you have a drink containing alcohol? □Monthly or less □2-4x/month □2-4x/week □4x/week or more How many drinks containing alcohol do you have on a typical day when you are drinking? □1-2 □3-4 □5-6 □7-9 □10 or more □Yes □No Have you ever had an addiction problem that required treatment or rehab? If yes, please check all that apply: □Alcohol □Illegal (street) drugs □Prescription drugs □Other addiction(s): _____
Family History	Father's present age: _____ OR age at death: _____ Cause of death:_____ Health problems: _____ Mother's present age: _____OR age at death: _____ Cause of death:_____ Health problems: _____

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Please check the box(s) if there is a family history of:

	Mother	Father	Sister	Brother	Other Family
Obesity	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Malignant hyperthermia	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Gastric cancer	☐	☐	☐	☐	☐
Pulmonary embolus	☐	☐	☐	☐	☐
Blood clotting or bleeding disorders	☐	☐	☐	☐	☐
Malignant hyperthermia	☐	☐	☐	☐	☐
Lung disease, asthma, emphysema	☐	☐	☐	☐	☐

Endocrine	□Yes □No Have you been told that you are pre-diabetic or have high blood sugars? **□Yes □No Do you currently have diabetes?** □Yes □No Do you take insulin? □Yes □No Do you take oral diabetic medication? □Yes □No Do you use diet only to treat your diabetes? □Yes □No Do you take medication for thyroid disease? □Yes □No Have you ever used steroids for any medical problem(s) in the past year? □Yes □No Have you ever been diagnosed with sickle cell disease or trait? □Yes □No Are you HIV positive or do you AIDS?

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Pulmonary (Lungs)	□Yes □No Have you been under the care of a lung specialist (Pulmonologist) in the last 2 years? □Yes □No Do you get short of breath walking up a flight of steps? □Yes □No Do you get short of breath walking a city block? □Yes □No Do you have a history of bronchitis? □Yes □No Do you have asthma? If yes: □Yes □No Do you inhaler daily? □Yes □No Do you use nebulizer treatments? □Yes □No Do you use oxygen? □Yes □No Have you been hospitalized for asthma within the last 2 years? □Yes □No Is your asthma well controlled? **□Yes □No Have you ever been diagnosed with sleep apnea? If yes:** □Yes □No Do you use an oral appliance? □Yes □No Do you use a CPAP machine/BIPAP machine? □Yes □No Do you use nighttime oxygen? □Yes □No Have you had surgery for the treatment of sleep apnea? □Yes □No Do you snore when you sleep? □Yes □No Do you wake up at night trying to catch your breath? □Yes □No Do you routinely sleep in a recliner chair at night? □Yes □No Do you have a chronic cough? □Yes □No Have you ever been diagnosed with COPD or emphysema?
Cardiac	□Yes □No Have you been under the care of a heart specialist (cardiologist) in the last 5 years? **□Yes □No Do you have high blood pressure?** □Yes □No Do you take medication for high blood pressure? □Yes □No Have you seen a doctor for irregular heartbeats? □Yes □No Do you take medication for irregular heartbeats? □Yes □No Have you been told that you have a heart murmur? □Yes □No Have you been told that you have mitral valve prolapsed? □Yes □No Do you currently have angina (Chest Pain)? If yes, do you have chest pain: □While sitting still? □While walking? □With strenuous work/exercise □Yes □No Have you ever had a heart attack? □Yes □No Have you ever had an abnormal EKG (heart tracing)? □Yes □No Have you ever had a cardiac (heart) catheterization? □Yes □No Have you ever had a heart treadmill or chemical stress test? □Yes □No Have you ever been told that you have congestive heart failure? □Yes □No Have you ever been hospitalized for heart failure? □Yes □No Have you ever had an angioplasty or cardiac stents placed for your heart disease? □Yes □No Are you on blood thinner medication for treatment of your heart disease?

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Cardiac	□Yes □No Do you have leg, ankle, or feet swelling? □Yes □No Are you on medication for leg, ankle, or feet swelling? □Yes □No Have you ever had blood clots in your legs (DVT)? □Yes □No Were you treated with blood thinners? □Yes □No Have you ever had blood clots in your lungs (pulmonary embolus)? □Yes □No Were you treated with blood thinners? □Yes □No Have you been treated for leg, ankle, or foot ulcers (venous status ulcers)? □Yes □No Do you have varicose veins? If yes, please circle: Right Leg Left leg Both □Yes □No Have you ever had an IVC filter placed for blood clots? □Yes □No Have you ever had a stroke? □Yes □No Have you ever been told that your cholesterol level was high? □Yes □No Do you take medication for high cholesterol levels? **□Yes □No Have you ever been told that you have high triglyceride levels?** □Yes □No Do you take medication for high triglyceride levels?
GI (Stomach/Intestines)	□Yes □No Have you seen a GI specialist (gastroenterologist) in the past 2 years? □Yes □No Do you have frequent difficulty chewing or swallowing? □Yes □No Do you suffer from difficulty having bowel movements (constipation)? □Yes □No Do you use stool softeners routinely? □Yes □No Do you have frequent loose stools (diarrhea)? □Yes □No Do you use anti-diarrhea medication routinely? □Yes □No Do you or have you had hemorrhoids? □Yes □No Do you suffer from heartburn (acid reflux)? □Yes □No Do you routinely take over the counter medications for heartburn? □Yes □No Do you take prescription medications for heartburn (GERD)? □Yes □No Have you ever been told that you have a hiatal hernia? (hernia In diaphragm). □Yes □No Have you ever had a stomach or duodenal ulcer? □Yes □No Have you ever been diagnosed with irritable bowel syndrome? □Yes □No Are you lactose intolerant? □Yes □No Have you ever been diagnosed with Crohn's disease? □Yes □No Have you ever been diagnosed with ulcerative colitis? □Yes □No Have you ever been diagnosed with cirrhosis? □Yes □No Have you ever been diagnosed with a fatty liver? □Yes □No Have you ever been diagnosed with hepatitis? □Yes □No Have you ever been diagnosed with celiac sprue? □Yes □No Have you ever been treated for pancreatitis? □Yes □No Have you ever had a previous weight-loss surgery?

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HEENT/NEURO (HEAD)	□Yes □No Do you have frequent headaches or migraines? □Yes □No Do you have memory loss/dementia/Alzheimer's? □Yes □No Do you suffer from hearing loss? Circle: Right Left Both □Yes □No Do you wear glasses, contacts, or use reading glasses? □Yes □No Do you suffer from chronic balance problems (vertigo)? □Yes □No Have you ever had a seizure? □Yes □No Are you currently taking any medications to prevent seizures? □Yes □No Have you ever been diagnosed with multiple sclerosis (MS)? □Yes □No Have you ever been diagnosed with pseudotumor cerebri? If yes, □Yes □No Does this cause headaches? □Yes □No Do you have nausea, dizziness, vision problems with your headaches? □Yes □No Has surgical treatment been recommended for you? If yes, have you received surgical treatment? □Yes □No
Bones/Joints/Muscles	□Yes □No Have you ever been diagnosed with arthritis? If yes, which one- □Rheumatoid arthritis □Osteoarthritis □Degenerative joint disease □Other arthritis not listed above □Yes □No Do you have joint pain that limits your activity level? Circle: Hip, Knee, Ankle, Shoulder, or Back Right Left Both □Yes □No Have you ever been diagnosed with gout? If yes, □Yes □No Do you currently take medication(s) for gout? □Yes □No Do you use a cane or walker to help you walk? Circle- Sometimes Always □Yes □No Do you use a motorized scooter or wheelchair? Circle- Sometimes Always □Yes □No Have you ever been diagnosed with a herniated disc(s)? □Yes □No Have you ever been told that you have carpal tunnel disease? □Yes □No Have you ever been diagnosed with scleroderma? □Yes □No Have you ever been diagnosed with fibromyalgia? If yes, how is it treated: □Exercise □Surgical intervention done or recommended □Non-narcotic medications □Disabling- no treatment has been effective □Yes □No Have you ever been diagnosed with lupus? □Yes □No Are you currently under the care of an orthopedic surgeon or neurosurgeon?
Cancer	□Yes □No Have you ever been diagnosed with a cancer other than skin cancer? If yes, what kind of cancer/when: _____ □Yes □No Do you have a clotting/bleeding disorder? □Yes □No Have you had a DVT (deep vein thrombosis)? □Yes □No Have you ever had a blood clot in your lung (pulmonary embolism)?

Bladder/Kidney	□Yes □No Do you have to urinate frequently? □Yes □No Do you have pain with urination? □Yes □No Do you have blood in your urine? □Yes □No Have you been told that you have protein in your urine? □Yes □No Have you ever had a kidney stone? □Yes □No Do you have leakage of urine with laughing/coughing/sneezing? If yes: □ Occurs less than once per week □Greater than one occurrence per week □Occurs daily □Is disabling □Yes □No Do you have leaking of stool(feces) with laughing/coughing/sneezing? □Yes □No Have you ever had a bladder infection (UTI)? □Yes □No Have you ever had a kidney infection?
Psychological	□Yes □No Have you ever been diagnosed with depression? If yes, □Yes □No Do you require medications for your depression? □Yes □No Is your depression occasional or episodic? □Yes □No Does your depression prevent you from caring for yourself? □Yes □No Does your depression prevent you from keeping a job? □Yes □No Have you ever required hospitalization for depression? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your depression? □Yes □No Is your depression being treated by your family doctor? □Yes □No Have you ever been diagnosed with anxiety/panic attacks? If yes, □Yes □No Do you require medications for anxiety? □Yes □No Is your depression only occasional or episodic? □Yes □No Does your anxiety prevent you from maintaining employment? □Yes □No Have you ever required hospitalization for anxiety? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your anxiety? □Yes □No Is your anxiety being treated by your family doctor? □Yes □No Have you ever been diagnosed with having a bipolar disorder? If yes, □Yes □No Do you require medications for your bipolar disorder? □Yes □No Does your bipolar disorder prevent you from

Psychological	caring for yourself? □Yes □No Does your bipolar disorder prevent you from keeping a job? □Yes □No Have you ever required hospitalization for bipolar disorder? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your bipolar disorder? □Yes □No Is your bipolar disorder being treated by your family doctor? □Yes □No Have you ever been diagnosed with schizophrenia or any other form of personality disorder or mental illness? □Yes □No Have you been hospitalized for any form of mental Illness or breakdown?
Gyn **(For Women Only)**	□Yes □No Have you ever had a fertility workup? □Yes □No Are you currently pregnant? □Yes □No Do you have monthly periods? □Yes □No Are your periods irregular? □Yes □No Do you have abnormality heavy or prolonged menstrual periods? □Yes □No Have you ever been pregnant? If so, during any pregnancy, did you have: □Yes □No Diabetes □Yes □No Low iron levels □Yes □No High blood pressure □Yes □No Pre-eclampsia □Yes □No Are you currently going through or in menopause? □Yes □No Are you currently using oral contraceptives? □Yes □No Are you currently using any other form of contraception? □Yes □No Have you ever been diagnosed with polycystic ovarian disease (PCOS)? If yes: □Yes □No Are you being treated with oral contraceptives? □Yes □No Are you being treated with metformin? □Yes □No Are you being treated with any other medication(s)? □Yes □No Have you been told that you are infertile? □Yes □No Have you had a Pap test done in the last two years? □Yes □No Have you ever had an ectopic pregnancy? □Yes □No Do you receive a gynecological exam yearly?

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Surgical History	Have you ever had any of the following types of surgery: □Anti-reflux procedure □Hip replacement □Appendix removed (appendectomy) □Knee replacement Year:_____ □Bowel Resection, Type:_____ Laminectomy (spine decompression) □Breast cancer biopsy Year/Results: _____ □Removal of a back disc (discectomy) □Breast cancer mastectomy (breast removal) Year:_____ □ Nissen fundoplication □Breast cancer radiation □Peripheral vascular (blood vessels in Year:_____ Arms and legs) procedures □Gallbladder removal (cholecystectomy) □Tubal ligation Year:_____ □Open heart surgery Year:_____ □Vagotomy (division of vagus nerve) □Hysterectomy Year:_____ □Vasectomy Other surgeries not listed above (include any biopsy or cosmetic surgery) _____ _____ _____
	Please list any prescription medications that you are currently taking: Name Dosage Instruction Reason for Medication _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
OTC and Herbal Products	Please list any OTC (over the counter) medications or herbals that you are currently taking: _____ _____ _____

	_____ _____
Allergies	□Yes □No Are you allergic to any medications? If yes please list any adverse Reaction—such as hives, rash, shortness of breath, or anaphylaxis: _____ _____ _____ _____ _____ □Yes □No Do you have a latex allergy? □Yes □No Are you allergic to shellfish, iodine, or contrast dye?
Family Provider/PCP	Name:_____ Address:_____ _____ Phone Number: _____ Last Visit: _____

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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

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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: _____

_____