The Maryland Bariatric Center AT MERCY

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PATIENT INFORMATION:

Last Name	First Name		M.I.
Home Address	City	State	Zip code
Home Phone	Cell Phone		
Date of Birth	Social Security #	Gender	
E-mail Address			

GENERAL INFORMATION:

Needs interpreter?	Preferred language	Birth Country
Marital status	Written language	Ethnicity
Religion	Race	
Employment Status	Employer	

PRIMARY INSURANCE INFORMATION:

Insurance Company Name	Policy Effective Date	Policy Holder's Name/ Relationship	
ID #	Group #	Policy Holder's Gender	Policy Holder's Date of Birth

SECONDARY INSURANCE INFORMATION: (IF NONE, SKIP TO PHARMACY SECTION)

Insurance Company Name	Policy Effective Date	Policy Holder's Name/ Relationship	
ID #	Group #	Policy Holder's Gender	Policy Holder's Date of Birth

PRIMARY CARE INFORMATION:

Primary Care Name	Address/ Phone Number:

PHARMACY INFORMATION:

Pharmacy Name	Address/ Phone Number:

EMERGENCY CONTACT INFORMATION:

Name		Relationship to Patient
Home Phone	Work Phone	Cell Phone

PATIENT HISTORY FORM

Knowing your detailed medical history information is very important for our assessment of your health. Obesity and its associated diseases and risk factors increase mortality and surgical complications. **We rely on the information you provide; therefore it is imperative for safety and insurance purposes that a detailed medical history be performed.**

I am also aware of the following:

- **NO tobacco products are permitted for 8 weeks before surgery- this gives your lungs a chance to better provide oxygen to your blood, which can help decrease the risk of infection, pneumonia, and especially improve wound healing.**
- **Second hand smoke is also irritating to the lungs.**
- **We will not operate on any patient that is an active smoker and may require you to takea laboratory test that confirms you are smoke free.**

PATIENT STATEMENT

I am aware that bariatric surgery is not a "quick fix" but rather a tool for controlling weight, combined with exercise and proper nutrition. I understand that bariatric surgery is not appropriate for everyone, and whether I am selected as a candidate for surgery is at the discretion of the bariatric surgeon. If I am determined to be a candidate for bariatric surgery, I am aware that I will be expected to follow up post op on a regular basis, and be required to take vitamins, and supplements for the rest of my life. I am also aware that reversal of this surgery is not recommended. The information on my medical history form is true and correct to the best of my belief.

_____

Patient's signature

_____

Date

WEIGHT LOSS HISTORY (For Bariatric Surgery Patients to complete):

Current Weight: _____ Current Height: _____

Most insurance companies require documented evidence of previous weight loss attempts so it is critical that you fill this out in detail. Please include dates as well as length of time of each diet, to the best of your knowledge.

1. What weight loss attempts have you made in the past?

___ Commercial weight loss programs (e.g., Weight Watchers, Jenny Craig) ___ Dieting ___ Exercise

___ Weight loss medications ___ Other (please specify): _____

2. For each weight loss attempt, please provide the following information:

Attempt #1:

Type of Attempt: _____

Dates (start and end): _____

Length of Time (e.g., 3 months): _____

Completed a recent diet for this visit? [Yes/No]: _____

Best Weight Loss Achieved: _____ lbs

Attempt #2:

Type of Attempt: _____

Dates (start and end): _____

Length of Time (e.g., 6 months): _____

Completed a recent diet for this visit? [Yes/No]: _____

Best Weight Loss Achieved: _____ lbs

3. **Additional Comments or Information: (Use this space to provide any additional details about your weight loss history, challenges, or successes that you believe are relevant.)**

_____
_____
_____

ALLERGIES

Allergy	Severity	CONDITION

____ Latex allergy? ____ Reaction to anesthesia?

MEDICATIONS (Report name, dose, and frequency and what you are taking it for)

MEDICATION	DOSAGE	FREQUENCY	CONDITION

SOCIAL

Home Life:

1. **Living Situation (e.g., alone, with family, with roommates): _____**
2. **Family Members or Housemates: (List names and relationships)**
   a. **_____**
   b. **_____**
   c. **_____**

(Continue if more family members or housemates are present)

3. **Dependents (e.g., children or elderly family members you care for):**
   _____

Social Support:

1. **Do you have a support system in place? (e.g., family, friends) [Yes/No]**
2. **Are there people you can rely on for emotional or practical support?**

   _____

Social Activities and Interests:

1. **Hobbies or interests outside of work and home life: _____**
2. **Community involvement or social activities: _____**

Do you have any other habits or behaviors that may impact your health? (e.g., smoking, recreational drug use, excessive caffeine consumption) [Yes/No]

If yes, please describe:

_____

_____

<u>REVIEW OF SYSTEMS</u> (Please check, circle and/or explain any of the items listed)

<u>CARDIOVASCULAR</u>

Heart Disease	**Chest Pains**	**Previous Heart Attack**	**High Blood Pressure**
Shortness of Breath	**While exercising?**	**High Cholesterol**	**Previous Blood Clot or PE**
High Triglycerides	**Fatigue**		

<u>DIABETES AND ENDOCRINE SYSTEM</u>

Diabetes Type (Circle one): Type 1 Type 2 Pre-Diabetes

Diabetes Diagnosis:

1. When was your diabetes first diagnosed? _____
2. How old were you at the time of diagnosis? _____

Medications and Insulin:

1. How long have you been taking oral diabetes medications? _____
2. How long have you been taking insulin? _____

Diabetes Resolution with Weight Loss:

1. Does your diabetes resolve with weight loss? [Yes/No] _____
2. Glycated Hemoglobin (A1C): _____
3. Abnormal Glucose Test (A1C) Value: _____

Gestational Diabetes:

1. Have you ever had gestational diabetes? Yes No
2. If yes, how old were you when you had gestational diabetes? _____

Low Blood Sugar (Hypoglycemia):

1. Have you experienced low blood sugar (hypoglycemia)? Yes No
2. Low Blood Sugar Value: _____

Thyroid Problems:

Have you had thyroid problems requiring medication? Yes No

GASTROINTESTINAL

Gallbladder Problems:

1. Do you have gallstones diagnosed by ultrasound? Yes No
2. Have you had your gallbladder removed, open or laparoscopically? Yes No

Stomach Ulcers:

1. Have you ever taken medicine for ulcers? Yes No

Heartburn:

1. How often do you experience heartburn, and do you take medications for it?
   _____

RESPIRATORY

Respiratory Conditions:

1. Asthma:
   a. Do you have asthma? Yes No
   b. Date of your last asthma attack (if applicable): _____
2. COPD (Chronic Obstructive Pulmonary Disease):
   a. Do you have COPD? Yes No
   b. Date of your last COPD exacerbation (if applicable): _____
3. Bronchitis:
   a. Have you had bronchitis? Yes No
   b. Date of your last bronchitis episode (if applicable): _____
4. Pneumonia:
   a. Have you had pneumonia? Yes No
   b. Date of your last pneumonia episode (if applicable): _____
5. Blood Clots:
   a. Have you had blood clots in your lungs? Yes No
   b. Have you had blood clots in your legs? Yes No

Smoking History:

1. At what age did you start smoking? _____
2. What YEAR did you stop smoking (if applicable)? _____

MUSCULOSKELETAL (Please Check All That Apply)

	Mild	Moderate	Severe
Hip Pain	☐	☐	☐
Knee Pain	☐	☐	☐
Ankle Pain	☐	☐	☐
Feet Pain	☐	☐	☐
Back Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Arthritis	☐	☐	☐

Medications:

Are you currently using anti-inflammatory or pain medications? Yes No

Swelling:

Do you have swelling of your legs? Yes No

Do you have swelling of your feet? Yes No

Vascular Issues:

Do you have varicose veins? Yes No

Have you had ulcers of the leg? Yes No

KIDNEY & BLADDER:

Do you have renal insufficiency or failure? Yes No

Have you had bladder or kidney infections? Yes No

Have you had kidney stones? Yes No

BLOOD:

Have you ever had a bleeding problem? Yes No

Have you ever had low platelets? Yes No

Have you ever had a blood transfusion? Yes No

NEURO-PSYCHIATRIC

Depression/Anxiety:

1. Have you experienced depression or anxiety, and do you believe it's related to obesity? Yes No
2. Are you currently taking medication for depression or anxiety? Yes No

Seizures:

Have you experienced seizures? Yes No

Are you currently taking medication for seizures? Yes No

Severe Headaches:

Have you experienced severe headaches? Yes No

Are you currently taking medication for severe headaches? Yes No

Visual Problems:

Have you experienced visual problems? Yes No

PAST SURGICAL HISTORY

1. Tonsillectomy: Yes No Year of tonsillectomy: _____
2. Cholecystectomy (Gallbladder Removal): Yes No Year of cholecystectomy: _____
3. Appendectomy: Yes No Year of appendectomy: _____
4. Hysterectomy (Removal of Uterus): Yes No Year of hysterectomy: _____
5. Cesarean Section (C-section): Yes No Year of C-section: _____
6. Oophorectomy (Removal of Ovary): Yes No Year of oophorectomy: _____
7. Hiatal Hernia Surgery: Yes No Year of hiatal hernia surgery: _____

Previous Bariatric Surgery:

1. Have you had previous bariatric surgery? Yes No
    a. If yes, please specify the surgeon: _____
    b. Year of bariatric surgery: _____
    c. Where was the surgery performed? _____
    d. Highest Weight before bariatric surgery: _____
    e. Lowest Weight after bariatric surgery: _____

Cardiac Surgery:

Have you had cardiac surgery? Yes No

Other Surgeries:

Please list any other surgeries you've had, along with the respective years:

1. Surgery: _____ Year: _____

2. Surgery: _____ Year: _____

3. Surgery: _____ Year: _____

4. Surgery: _____ Year: _____

5. Surgery: _____ Year: _____

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

Family History					
	Mother	**Father**	**Sibling**	**Aunt/Uncle**	**Grand Parent**
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Cancer					
Arthritis					
Depression					
Blood Clots/PE					
Early Death					
Cause					

FOR WOMEN ONLY

Polycystic Ovarian Syndrome (PCOS):

1. Have you ever been diagnosed with polycystic ovarian syndrome (PCOS)? Yes No

Fertility and Pregnancy:

1. Have you had problems conceiving? Yes No
2. How many pregnancies have you had? _____
3. How many children do you have? _____

Menstrual Health:

1. Do you experience any pain with your periods? Yes No