Bariatric Health History

CHI Franciscan Health

Our best care. Your best health.℠

Franciscan Center for Weight Management | St. Francis Hospital

FranciscanWeightLoss.org

Name: _____ Date of birth: _____

Today's date: _____

This information is very valuable in assisting us in our thorough evaluation. Please fill it out as completely as possible to the best of your knowledge.

Previous surgeries and approximate dates: _____

_____

_____

Medical conditions, major illnesses, hospitalizations or injuries and approximate dates: _____

_____

_____

Current medication and dosage (including supplements): _____

_____

_____

Allergies to medications: _____

Who lives with you? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Have you smoked in the past? ☐ Yes ☐ No If so, when? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you use recreational drugs? ☐ Yes ☐ No Type and amount: _____

What is your occupation? _____

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ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

Fever	☐ Yes ☐ No	Sore throat	☐ Yes ☐ No	Nausea	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Chronic cough	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	Bloody stool	☐ Yes ☐ No
Painful urination	☐ Yes ☐ No	Unintentional weight loss	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Seizures	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Heartburn/reflux	☐ Yes ☐ No	Painful urination	☐ Yes ☐ No
Muscle aches	☐ Yes ☐ No	Recent changes in vision	☐ Yes ☐ No	Blood in urine	☐ Yes ☐ No
Joint pain	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Awake at night to urinate	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	Nose bleeds	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Venous ulcers	☐ Yes ☐ No	Asthma/lung disease	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No	Infertility	☐ Yes ☐ No	Waking up short of breath	☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Do you use a C-Pap machine? ☐ Yes ☐ No

Have you ever been told you stop breathing during sleep? ☐ Yes ☐ No

Have you ever had a sleep study done? ☐ Yes ☐ No When/where? _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Disease		If yes, when	Family history	Relation to you
Heart disease	☐ Yes ☐ No		☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No		☐ Yes ☐ No	
High cholesterol	☐ Yes ☐ No		☐ Yes ☐ No	
Cancer	☐ Yes ☐ No		☐ Yes ☐ No	
Obesity	☐ Yes ☐ No		☐ Yes ☐ No	

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Does your primary doctor know you are considering weight loss surgery? ☐ Yes ☐ No

Are they supportive of you considering weight loss surgery? ☐ Yes ☐ No

Does your family/significant other know you are considering weight loss surgery? ☐ Yes ☐ No

Are they supportive of you considering weight loss surgery? ☐ Yes ☐ No

Have you done any research on weight loss surgery? ☐ Yes ☐ No

What kind (check all that apply):

☐ Weight loss seminar ☐ Support groups ☐ Internet ☐ Television

☐ Radio ☐ Reading ☐ Someone I know had weight loss surgery

Other: _____

When was the first time you noticed being overweight?

☐ Lifelong ☐ High school ☐ After children

Other: _____

What has been your highest weight? _____ Lbs When was this: _____

Your greatest single weight loss? _____ Lbs How was this obtained: _____

How many times have you lost 25lbs? _____

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WHICH OF THE FOLLOWING DIET PROGRAMS HAVE YOU TRIED?

- ☐ Prescription medications
- ☐ Magazine diets
- ☐ Subliminal tapes
- ☐ Numerous book diets
- ☐ Herbal Life
- ☐ Hypnosis
- ☐ Medifast
- ☐ Optifast
- ☐ Low-calorie diets
- ☐ Overeaters Anonymous
- ☐ Weight Watchers
- ☐ Rader Institute
- ☐ Toppfast
- ☐ Self-imposed fasts
- ☐ Slimfast
- ☐ Jenny Craig
- ☐ Atkins diet
- ☐ Tops
- ☐ Over-the-counter medications
- ☐ Diet center
- ☐ South Beach diet
- ☐ Liquid protein
- ☐ Physician-supervised diets
- ☐ Mayo Clinic
- ☐ Nutri-System
- ☐ High protein/low carb diet

Other: _____

Is there anything else we should know about you? _____