

SUFFOLK SURGICAL GROUP, P.C.
Wellness & Weight Management Center

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MEDICAL HISTORY FOR BARIATRIC PATIENTS

NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

OCCUPATION: _____

MARITAL STATUS: ___ MARRIED ___ DIVORCED ___ SINGLE ___ PARTNERSHIP

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

HEADACHES	YES___ NO___	STRESS INCONTINENCE	YES___ NO___
SHORTNESS OF BREATH	YES___ NO___	INDIGESTION/HEARTBURN	YES___ NO___
COUGH	YES___ NO___	VOMITING	YES___ NO___
PALPITATIONS	YES___ NO___	ABDOMINAL PAIN	YES___ NO___
CHEST PAIN	YES___ NO___	BLOOD IN URINE/STOOL	YES___ NO___
DIZZINESS	YES___ NO___	DIFFICULTY URINATING	YES___ NO___
FATIGUE	YES___ NO___	PAIN/SWELLING IN LEGS	YES___ NO___
CONSTIPATION	YES___ NO___	VARICOSE VEINS	YES___ NO___
JOINT/MUSCLE PAINS	YES___ NO___	DEPRESSION	YES___ NO___
ANXIETY	YES___ NO___	INSOMNIA	YES___ NO___
SNORING	YES___ NO___	EXCESSIVE DAYTIME SLEEPINESS	YES___ NO___
IMPOTENCE	YES___ NO___	FALL ASLEEP INAPPROPRIATELY	YES___ NO___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING ILLNESSES/DISEASES?

HEART DISEASE	YES___ NO___	DIABETES	YES___ NO___
HIGH BLOOD PRESSURE	YES___ NO___	HEART ATTACK	YES___ NO___
STROKE	YES___ NO___	HIGH CHOLESTEROL	YES___ NO___
ASTHMA	YES___ NO___	EMPHYSEMA/COPD	YES___ NO___
DEPRESSION	YES___ NO___	CONGESTIVE HEART FAILURE	YES___ NO___
ARTHRITIS	YES___ NO___	CANCER	YES___ NO___
KIDNEY DISEASE	YES___ NO___	GLAUCOMA/EYE PROBLEMS	YES___ NO___
SLEEP APNEA	YES___ NO___	GALLBLADDER DISEASE	YES___ NO___

GASTRO ESOPHAGEAL REFLUX DISEASE (GERD)	YES___ NO___		
POLY CYSTIC OVARIAN SYNDROME (PCOS)	YES___ NO___		
LUPUS/OTHER COLLAGEN DISEASE	YES___ NO___		
ULCER/GASTROINTESTINAL DISEASE	YES___ NO___		
THYROID DISEASE	YES___ NO___	HYPER OR HYPO (PLEASE CIRCLE ONE)	

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES? YES___ NO___ #OF CIGARETTES/DAY

IF NO, HAVE YOU EVER SMOKED CIGARETTES IN THE PAST?

YES___ NO___ # OF CIGARETTES/DAY DATE QUIT_____

DO YOU DRINK ALCOHOL? ___NO ___SOCIAL ___OCCASIONAL ___DAILY

DO YOU HAVE ANY HISTORY OF DRUG OR ALCOHOL ABUSE? YES___NO___

IF YES, PLEASE LIST: _____

FOR OUR FEMALE PATIENTS:

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____

ARE YOUR MENSTRUAL PERIODS REGULAR? YES___ NO___ AGE OF MENOPAUSE _____

DATE OF LAST PAP _____ DATE OF LAST MAMMOGRAPHY _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? NO YES IF YES, PLEASE LIST OR PROVIDE LIST (INCLUDE OVER THE COUNTER PREPARATIONS SUCH AS LAXATIVES, VITAMINS AND PAIN RELIEVERS):

MEDICATION	DAILY DOSE	FREQUENCY

* PLEASE INFORM RECEPTIONIST IF ADDITIONAL SPACE IS NEEDED

ARE YOU ALLERGIC TO ANY MEDICATIONS/FOOD? NO YES IF YES, PLEASE LIST:

PLEASE LIST ANY SURGERY OR HOSPITALIZATIONS, BEGINNING WITH THE MOST RECENT:

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____

DO ANY BLOOD RELATIVES HAVE / HAD:

	NO	YES	IF YES, WHO?
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREAST MASSES OR BREAST TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	_____

WHAT WOULD YOU SAY YOUR IDEAL WEIGHT IS? _____

HOW LONG HAVE YOU BEEN OVERWEIGHT? _____

LIST REASONS WHY YOU WANT WEIGHT LOSS SURGERY

LIST ALL DIETS YOU HAVE TRIED INCLUDING DIET PILLS

LIST WEIGHT LOSS CLINICS ATTENDED

LIST EXERCISE CLINICS ATTENDED

LIST DOCTORS YOU HAVE SEEN FOR WEIGHT LOSS

LIST INJECTIONS TRIED

LIST ACUPUNCTURE TRIED
