TMH PHYSICIAN PARTNERS

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Bariatric Surgical Specialists Medical History

Patient Name:_____**Date**:_____

Date of Birth: _____/_____/_____**Age**:_____ **Height**:_____ **Weight**:_____lbs **Race**:_____

MEDICAL SYSTEM EVALUATION

CENTRAL NERVOUS SYSTEM: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	SEIZURES			6.	SPINAL CORD INJURY		
2.	PSEUDOTUMOR CEREBRI			7.	PARALYSIS		
3	STROKE			8.	NEUROPATHY		
4	TRANSIENT ISCHEMIC ATTACKS (TIA)			9.	MOTION SICKNESS		
5	BRAIN INJURY			10	MIGRAINE HEADACHES		

Are you under the care of a neurologist or neurosurgeon? If so, please list the physician's name & address:

_____

PULMONARY: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	SLEEP APNEA			7.	CAN YOU CLIMB A FLIGHT OF STAIRS?		
2.	ASTHMA			8.	CAN YOU CLIMB TWO FLIGHTS OF STAIRS?		
3.	PNEUMONIA			9.	HAVE YOU BEEN TESTED FOR SLEEP APNEA?		
4.	COPD			10	DO YOU USE CPAP OF BiPAP?		
5.	SHORTNESS OF BREATH			11	DO YOU USE SUPPLEMENTAL OXYGEN?		
6.	SHORTNESS OF BREATH WITH EXERCISE			12	HAVE YOU HAD LUNG FUNCTIONING TESTING?		

Do you smoke? _____If yes, how many packs per day? _____How many years have you smoked? _____ Yrs.

If you have stopped smoking, how long ago did you stop smoking? _____ Yrs.

Are you under the care of a pulmonologist/lung specialist? If so, please list the physician's name & address?

_____

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CARDIAC AND BLOOD VESSELS: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	HIGH BLOOD PRESSURE			6.	SURGERY ON BLOOD VESSELS IN THE NECK, ARMS OR LEGS?		
2.	CORONARY ARTERY DISEASE			7.	HEART ARRTHYMIAS		
3.	HEART ATTACK			8.	HAVE YOU HAD A CARDIAC STRESS TEST?		
4.	HEART VALVE SURGERY			9.	HAVE YOU HAD A HEART CATHETERIZATION?		
5.	HEART VALVE SURGERY			10	HAVE YOU HAD A CORONARY STENT PLACED?		

If you responded with a yes to answers related to heart attack, procedure or surgery, please comment on when this occurred._____

_____

Are you under the care of a cardiologist or cardiac surgeon? If yes, please list the physician's name & address:

_____

GASTROINTESTINAL: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	INDIGESTION			6.	MILK INTOLERANCE		
2.	IRRITABLE BOWEL SYNDROME			7.	CIRRHOSIS		
3.	GASTROESOPHAGEAL REFLUX DISEASE			8.	GALLSTONES		
4.	CONSTIPATION (CHRONIC)			9.	HAS YOUR GALLBLADDER BEEN REMOVED?		
5.	DIARRHEA (CHRONIC)			10	HAVE YOU HAD A GALLBLADDER ULTRASOUND?		

If answer to #9 was yes, was the procedure laparoscopic? _____ Have you had any other abdominal surgeries?

_____

Are you under the care of a gastroenterologist? If yes, please list the physician's name & address:

_____

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ENDOCRINE: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	THYROID DISEASE			3.	POLYCYSTIC OVARY DISEASE		
2.	THYROID CANCER			4.	DIABETES		

Are you under the care of an endocrinologist? If yes, please list the physician's name & address:

_____

GENTOURINARY: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO	FOR FEMALE PATIENTS ONLY:	YES	NO
1.	KIDNEY STONES			3. IRREGULAR PERIODS		
2.	STRESS INCONTINENCE/URINARY LEAKAGE			4. PAINFUL PERIODS 5. OVARIAN CYST 6. INFERTILITY 7. HEAVY PERIODS 8. HYSTERECTOMY		

Are you under the care of a Urinary Specialist or Gynecologist? If yes, please list name and address.

_____

DIETARY HISTORY

WHAT IS THE MOST YOU EVER WEIGHED? _____ LBS

HOW MANY DIETS HAVE YOU ATTEMPTED _____ 0-5 _____ 5-10 _____ >10

WHAT IS THE MOST WEIGHT YOU HAVE LOST ON A DIET OR WITH DIET PILLS? _____ LBS

HAVE YOU ATTEMPTED WEIGHT LOSS UNDER THE SUPERVISION OF A PHYSICIAN? _____ If yes, please list the physician's name & address: _____

_____

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MUSCULOSKELETAL SYSTEM: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	NECK PAIN			8.	OTHER JOINT PAIN		
2.	UPPER BACK PAIN			9.	ARTHRITIS		
3.	LOW BACK PAIN			10	DEGENERATIVE JOIN DISEASE		
4.	HIP PAIN			11	ARTHROSCOPIC SURGERY		
5.	KNEE PAIN			12	JOINT REPLACEMENT SURGERY		
6.	ANKLE PAIN			13	FIBROMYALGIA		
7.	FOOT PAIN			14	HAVE YOU HAD OTHER BACK OR JOINT SURGERY?		

If you responded yes to the surgical questions, please list which joint was affected: _____

Are you under the care of an orthopedic surgeon or a rheumatologist? If yes, please list name & address:

_____

PSYCHIATRIC/PSYCOLOGIST: *DO YOU HAVE OR HAVE YOU HAD?*

		YES	NO			YES	NO
1.	BIPOLAR DISORDER			4.	SCHIZOPHRENIA		
2.	DEPRESSION			5.	DRUG ADDICTION		
3.	EATING DISORDER			6.	ALCOHOLISM		

Are you under the care of a psychiatrist, psychologist or counselor? If yes, please list the name & address:

_____

_____