PIKEVILLE MEDICAL CENTER

# Bariatric Surgery Patient History

(Please Print)

**Please present your insurance card(s) to the receptionist so we may obtain a copy for billing purposes.**

Today's Date: ____/____/____
Patient's Last Name: _____ Patient's First Name (**Legal Name**): _____
Middle Name: _____ Nick Name: _____ Maiden Name:_____
Social Security Number: _____ DOB: _____
Marital Status (check one): ___Single ___Married ___Divorced ___Widowed
Mailing Address: _____ City: _____
State: _____ Zip: _____ Home Phone Number: _____ E-mail:_____
Cell Phone Number: _____ Occupation: _____
Are you employed: Yes or No Are you a student: Yes or No Full-time or Part-time School:_____
Employer: _____ Work Phone Number: _____

Emergency Contact Name: _____
Emergency Contact Phone Number: _____

Person responsible for payment of this account will be: (Please Check One)
___Patient ___Parent ___Other
If other please specify: _____
Legal Name: _____
Mailing Address: _____
City: _____ State: _____ ZIP:_____
Telephone: _____ E-mail:_____
Social Security Number: _____
Employer: _____

Doctor who referred you:

_____

**Insurance Information:**
Primary Insurance Name: _____
Policy Holder Name: _____
Policy Number: _____ Group Number: _____

Secondary Insurance Name: _____
Policy Holder Name: _____
Policy Number: _____ Group Number: _____

Tertiary Insurance Name: _____
Policy Holder Name: _____
Policy Number: _____ Group Number: _____

**SPECIAL PERMISSIONS**

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW

1. I give permission to leave voice mail or answering machine messages at my home.
   Yes or No _____Initials _____Date

2. I give permission to call me on my cell phone. Yes or No _____Initials _____Date

3. I give permission to call me at work. Yes or No _____Initials _____Date

4. I give permission to discuss my medical and billing information with _____ and _____. Yes or No _____Initials _____Date

**I HAVE REVIEWED THE ABOVE INFORMATION, AND TO THE BEST OF MY KNOWLEDGE, IT IS CORRECT AND COMPLETE.**

_____ _____ _____
**(Signature of Patient or Guardian)** **Date** **(Relationship to Patient)**

PIKEVILLE MEDICAL CENTER

## PEOPLE LIVING IN YOUR HOUSEHOLD

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## HEALTH CARE PROVIDERS/MEDICAL

Primary Care Provider: _____ Phone: _____ Fax: _____
Address : _____ E-mail:_____

Therapist or Mental health Counselor_____
Address: _____
Phone: _____ Fax: _____ E-mail:_____

Please list all other medical health providers and specialist. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

Provider name: _____ Specialty: _____
Address _____
Phone: _____ Fax: _____ E-mail:_____

Provider name: _____ Specialty: _____
Address _____
Phone: _____ Fax: _____ E-mail:_____

Provider name: _____ Specialty: _____
Address _____
Phone: _____ Fax: _____ E-mail:_____

## ALCOHOL, TOBACCO, AND NON-PRESCRIPTION DRUG HISTORY

Current use: List all alcohol, tobacco, and non-prescription drugs and the amounts that you currently use. List any additional products on the back of this page. How often?

| | **Type of Product** | **Amount per day** | **Per Day** | **Per Week** |
|---|---|---|---|---|
| Alcohol: | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Tobacco: | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Drugs: | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |

When did you stop/plan to stop using?

Alcohol: _____ Tobacco: _____ Drugs: _____

PIKEVILLE MEDICAL CENTER

**FAMILY HISTORY**
Please check any of the following conditions that your parents, siblings, or your children have ever experienced.

❑ Obesity ❑ Diabetes ❑ Heart Disease ❑ High Cholesterol/Triglycerides ❑ High Blood Preassure

**PRESCRIPTION MEDICATIONS, SUPPLEMENTS AND REMEDIES**
Please list all your current medications, supplements and remedies. If you need additional space, please continue on the back of this page.

**Prescription drugs and dosages** (including psychiatric medication and birth control)

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Over the counter drugs:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Vitamins/supplements/herbal remedies:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Allergies to any medications:**

| **Allergy** | **Reaction** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**HOSPITALIZATIONS**
Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

| Approximate Date | Problem | Hospital/Treatment Facility | Doctor/Care Provider |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PIKEVILLE MEDICAL CENTER

## PREVIOUS NON-BARIATRIC SURGERIES

Procedure:

- ❑ Anti-reflux procedure
- ❑ Breast Cancer, biopsy
- ❑ Removal of gallbladder
- ❑ Knee replacement
- ❑ Peripheral vascular Procedure
- ❑ C-section
- ❑ Bowel resection
- ❑ Breast cancer, radiation
- ❑ Hip replacement
- ❑ Laminectomy
- ❑ Tubal ligation
- ❑ Other _____
- ❑ Breast cancer, mastectomy
- ❑ CABG
- ❑ Hysterectomy
- ❑ Nissen Fundoplication
- ❑ Vasectomy

## PREVIOUS BARIATRIC SURGERIES

- ❑ Bilopancreatic diversion (BPD)
- ❑ Gastric banding, adjustable
- ❑ Gastric bypass, (Roux-en-Y) open
- ❑ Gastric pacing
- ❑ Intestinal Bypass
- ❑ Vertical banded Gastroplasty
- ❑ Gastrectomy
- ❑ Gastric band, non-adjustable
- ❑ Gastric bypass(Roux-en-Y) with distal gastrectomy, laparoscopic
- ❑ Sleeve gastrectomy
- ❑ Gastric bypass, mini loop
- ❑ Gastric bypass, banded
- ❑ Gastric bypass(Roux-en-Y) with distal gastrectomy, open
- ❑ BPD with duodenal switch

Year: _____ Original weight: _____ ____lbs ❑ estimated ❑ actual

Lowest weight achieved _____ ____lbs ❑ estimated ❑ actual

Hospital:_____ Surgeon: _____

## CURRENT MEDICAL CONDITIONS

Please check box and add information.

**Heart and Circulation:** Comments

- ❑ Chest pain/coronary artery disease/angina _____
- ❑ Congestive Heart Failure _____
- ❑ Irregular or rapid heart beat (arrhythmias) _____
- ❑ Peripheral vascular disease _____
- ❑ Leg swelling (edema) _____
- ❑ Hypertension/high blood pressure _____
- ❑ Stroke _____
- ❑ Blood Clots/Deep Vein Thrombosis (DVT) _____
- ❑ Other:_____ _____

**Lungs:**

- ❑ Shortness of breath _____
  - ❑ at rest ❑ walking on flat ground ❑ on stairs/hills
- ❑ Asthma _____
- ❑ COPD (emphysema, chronic bronchitis) _____
- ❑ Pulmonary Embolism (Blood clot in the lungs)_____
- ❑ Sleep Apnea _____ CPAP settings_____ _____
- ❑ Pulmonary Hypertension
- ❑ Other: _____ _____

PIKEVILLE MEDICAL CENTER

**Gastrointestinal/GI:**

- ❑ Gastroesophageal Reflux (GERD)
- ❑ Heartburn
- ❑ Ulcers
- ❑ Crohn's Disease/Ulercative Colitis
- ❑ Frequent Diarrhea
- ❑ Frequent constipation
- ❑ Gallbladder ❑ stones ❑ removed
- ❑ Fatty liver
- ❑ Colon ❑ hemorrhoids ❑ polyps
- ❑ Liver ❑ hepatitis ❑ Cirrhosis
- ❑ Other: _____

**Endocrine:**

- ❑ Diabetes
- ❑ High cholesterol, high triglycerides
- ❑ Infertility
- ❑ Menstrual irregularities
- ❑ Polycystic Ovarian Syndrome
- ❑ Thyroid ❑ Hypothyroidism (Underactive)
  ❑ Hyperthyroidism (Overactive)
- ❑ Excessive hot or cold feeling
- ❑ Visual Changes
- ❑ Changes in your voice
- ❑ Recent increase in thirst or urination
- ❑ Abnormal hair growth
- ❑ Numbness or tingling in your hands or feet
- ❑ Other: _____

**MEDICAL HISTORY**

Blood: Comments

- ❑ Anemia
- ❑ Iron Deficiency
- ❑ Other:_____

**Musculoskeletal:**

- ❑ Back pain
- ❑ Gout
- ❑ Arthritis type: _____
- ❑ Fibromyalgia
- ❑ Other: _____

**Psychiatric:**

- ❑ Depression
- ❑ Bi-polar Disorder
- ❑ Eating Disorder ___Anorexia ___Bulimia
- ❑ Anxiety
- ❑ Other: _____

**Other:**

- ❑ Urinary Stress Incontinence
- ❑ Pseudotumor Cerebi
- ❑ Abdominal Skin/Pannus irritation/infection
- ❑ Abdominal Wall Hernia
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Other:_____

PIKEVILLE MEDICAL CENTER

## WEIGHT AND WEIGHT LOSS HISTORY

Current weight or best estimate _____ Current Height_____
Weight 1 year ago _____
Are you at your highest weight ever? ___Yes ___No
If your answered no, what was your highest weight and when? _____

Please check all previous weight loss methods that you have tried. List any additional

**Commercial diet programs**
- ❑ Weight Watchers
- ❑ Diet Workshop
- ❑ Jenny Craig
- ❑ OA
- ❑ TOPS
- ❑ Nutrisystem
- ❑ Other:_____
- ❑ Other:_____

**Prescription diet medications**
- ❑ Redu (dexfenfluraramine)
- ❑ Pondimin (fenfluramine)
- ❑ Phen-Fen
- ❑ Phentermine (Fastin,Adipex)
- ❑ Amphetamines
- ❑ Meridia (sibutramine)
- ❑ Other:_____
- ❑ Other_____

**Liquid Diets**
- ❑ Optifast
- ❑ HMR
- ❑ Slimfast
- ❑ Other: _____

**Herbal and non-prescription remedies**
- ❑ Epedra, ma huang
- ❑ Other herbals: _____
- ❑ Over the counter diet aids
- ❑ Other:_____

## WEIGHT AND WEIGHT LOSS HISTORY

**Therapy and Other Programs**
- ❑ Behavior therapy
- ❑ Psychotherapy
- ❑ Exercise programs
- ❑ Feeding Ourselves
- ❑ Self initiated or fad diets. Please list:

_____

**Medical and health Care Treatments**
- ❑ Previous gastric surgery/stapling
- ❑ Jaw wiring
- ❑ Other surgery: _____
- ❑ Acupuncture
- ❑ Hypnosis
- ❑ Other: _____