North Ottawa Community Health System

Bariatrics
History and Physical

Section One – History (To be completed by Patient)

Patient Name:	Date of Birth:	Today's Date:
Primary Care Physician: (PCP):	Office Phone Number:	
Referral Source:	**Program Interest:** ❑ Bariatric Surgery ❑ Medical Weight Loss ❑ Medication Management	

HT _____

WT_____

Medication Allergies and Reactions:

History of Eating Disorders (Check all that apply)

☐ Anorexia ☐ Bulimia ☐ Binge Eating Disorder ☐ Other

Weight History

Years Overweight:

Weight Loss Programs/Methods Attempted (Check all that apply and list dates)

☐ Weight Watchers	☐ Starvation
☐ Supervised Diet	☐ Fad Diets Type:
☐ Diet Pills Type:	☐ Other
☐ Counseling	

Have you ever been in a Physician Supervised Weight Loss Program? ☐ Yes ☐ No

Describe:

Past & Current Medical Problems (Check all that apply)

☐ High Blood Pressure	☐ Diabetes Mellitus Type 1	☐ Diabetes Mellitus Type 2	☐ Obesity	
☐ Coronary Artery Disease	☐ Congestive Heart Failure	☐ Arrhythmia		List Others:
☐ High Cholesterol	☐ Liver Disease	☐ Lung Disease		1.
☐ Kidney Disease	☐ Blood Clots	☐ Seizures		2.
☐ Arthritis	☐ Stroke	☐ Reflux Disease/GERD		3.
☐ Peptic Ulcer Disease	☐ Obstructive Sleep Apnea	☐ Bleeding Tendencies		4.
☐ Hypothyroidism	☐ Depression	☐ Anxiety		5.
☐ Polycystic Ovarian Disease	☐ MRSA	☐ Heartburn		6.

Past Surgical History (List Surgeries and Dates)

1.	4.
2.	5.
3.	6.

Have you ever had Bariatric Surgery_____ If YES, please list type of operation/date performed_____

Previous Bariatric Surgeon? _____ Please list the phone, fax and address so we may obtain those medical records.

Past Problems with Anesthesia? ❑ **Yes** ❑ **No** **Please explain.**

Will you accept blood transfusions (if necessary)? ☐ Yes ☐ No

Family History (Describe medical Diagnosis, Weight History, including blood clots)

	Father	Mother	Siblings	Children
	❑ Alive ❑ Deceased	❑ Alive ❑ Deceased	# of Brothers _____ # of Sisters _____	# of Children_____
Medical Problems				

Social History

Marital Status:	❑ Single	❑ Married	❑ Divorced	❑ Widow(er)
Caffeine	❑ Pop – Diet Quantity:	❑ Pop – Regular Quantity:	❑ Coffee Quantity:	❑ Tea Quantity:
Employed?	❑ Yes ❑ No	Type of Work?	❑ Disabled? Why?	
Alcohol Consumption	# Drinks per week: ❑ none ❑ 1-5 ❑ 6-10 ❑ 11-15 ❑ 16-20 ❑ >20			

Smoking: ❑ Never ❑ Former ❑ Current How often _____ Quit Date _____

Chewing Tobacco: ❑ Never ❑ Current

Nicotine: ❑ Patches ❑ Gum ❑ Vaporizer/E-cigarette

Drug Use: ❑ Never ❑ Current ❑ Past

If Current, what type: _____ Medical Marijuana Card? ❑ Yes ❑ No

Are you currently involved in an exercise program? (please describe)

Previous Medical Testing

Name of Test	Date	Doctor	Results
Sleep Study			C-pap? ❑ Yes ❑ No C-pap setting** _____
EKG			
Echocardiogram			
Heart Stress test			
Heart Catheterization			
Breathing Tests (PFT's)			
Upper Endoscopy (EGD)			
Colonoscopy (if > 50 yrs.)			
Ultrasound of Gallbladder			
DEXA Scan (women > 50 yrs.)			
Mammogram (women > 40 yrs.)			
Pap & Pelvic exam (women)			
Prostate exam (men > 40 yrs.)			
Have you had labs in the last 3 months? If yes, where?			

Medications

List Current Prescriptions	Dose	Time/Day	List Dietary Supplements, Herbs, Vitamins, etc.
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.
6.			6.

Do you take any blood thinning medications such as Coumadin, Warfarin, Aspirin, or Plavix? ❑ Yes ❑ No

Do you take any NSAIDS such as Ibuprofen, Motrin, Aleve, Celebrex, or Naprosyn? ❑ Yes ❑ No

Systems Review

(Check if it is a current problem)

General
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

HEENT
- ☐ Headaches
- ☐ New Vision Changes
- ☐ Dizziness

Cardiac
- ☐ Chest Pain or Pressure
- ☐ Palpitation
- ☐ Shortness of Breath with activity
- ☐ Shortness of Breath while lying down
- ☐ Waking up short of breath
- ☐ Leg Swelling

Musculoskeletal
- ☐ Joint Pain or Swelling
- ☐ Muscle Pain

Do you use any walking aids daily?
- ☐ Cane
- ☐ Wheelchair
- ☐ Walker
- ☐ Motorized Cart

Pulmonary
- ☐ Cough
- ☐ Wheezing
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Stop breathing while sleeping

Abdominal
- ☐ Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Heartburn/Reflux
- ☐ Difficulty Swallowing
- ☐ Abdominal Hernia
- ☐ Incisional Hernia

Endocrine
- ☐ Abnormal Hair Growth
- ☐ High Blood Sugars
- ☐ Thyroid Problems

Hematological
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Blood Clots

Neurological
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Fainting/Loss of consciousness

GU
- ☐ Urine Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Hesitancy
- ☐ Night time Urination

Mental Health
- ☐ Depressed Mood
- ☐ Anxiety

Specialty Physician
- ☐ Cardiologist
- ☐ Oncologist
- ☐ GI
- ☐ Neurologist
- ☐ Psychologist
- ☐ Other

Name:	Specialty:	Phone:	Fax:	Mailing Address:

Epworth Sleepiness Assessment

Situation	Chance of Dozing or Sleeping
Sitting and Reading	
Watching TV	
Sitting Inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total Score	

Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

An Epworth score of 10 or higher signifies Excessive Daytime Sleepiness