

## Bariatric Surgery Intake Form

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_

### EMERGENCY CONTACT

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not notify our office.

Next of Kin (not living with you) \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_

(C) (\_\_\_\_) \_\_\_\_\_

### PHYSICIANS

Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Cardiologist (Heart Doctor) \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Psychologist** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Psychiatrist** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Pulmonologist (Lung Doctor)** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Endocrinologist** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Orthopedic Surgeon** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Other Physician** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** ( \_\_\_\_\_ ) \_\_\_\_\_ **Fax** ( \_\_\_\_\_ ) \_\_\_\_\_

**Other Physician** \_\_\_\_\_

**Address** \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

**WEIGHT AND WEIGHT LOSS HISTORY**

**HEIGHT:** \_\_\_\_\_ feet \_\_\_\_\_ inches      **WEIGHT:** \_\_\_\_\_ pounds

**Age of obesity onset:**

\_\_\_\_\_ 0-2 years old      \_\_\_\_\_ 12-18 years old      \_\_\_\_\_ Pregnancy  
 \_\_\_\_\_ 2-12 years old      \_\_\_\_\_ Young adult      \_\_\_\_\_ Middle age

**How many years have you been at your present weight?** \_\_\_\_\_

**Greatest single weight loss:** \_\_\_\_\_ pounds

**Weight loss was sustained for:** \_\_\_\_\_ months

**Have you ever been on Phen/Fen (Phentermine/Fenfluramine)?** \_\_\_\_\_ No      \_\_\_\_\_ Yes

**If yes, did you take it for longer than six months?** \_\_\_\_\_ No      \_\_\_\_\_ Yes

**Please check "YES" if you participated in any of the following diet programs:**

<b>NAME OF PROGRAM</b>	<b>YES</b>	<b>YEAR(S)</b>
<b>Weight Watchers</b>		
<b>NutriSystem</b>		
<b>Pritikin</b>		
<b>Scarsdale</b>		
<b>Diet Center</b>		
<b>Jenny Craig</b>		
<b>Dexatrim</b>		
<b>Atkins</b>		
<b>Slim Fast</b>		
<b>Herbal diets</b>		
<b>TOPS</b>		
<b>Richard Simmons</b>		
<b>Low fat</b>		
<b>Cabbage Diet</b>		
<b>American Heart Association</b>		
<b>Radar Institute</b>		
<b>Optifast</b>		
<b>CareFast</b>		
<b>Medifast</b>		
<b>Meridia</b>		
<b>Xenical</b>		
<b>Fastin</b>		
<b>Ionamin</b>		
<b>Redux</b>		
<b>Other:</b>		
<b>Other:</b>		

**Five year weight history:**

<b>YEAR</b>	<b>WEIGHT (pounds)</b>
<b>2008</b>	
<b>2007</b>	
<b>2006</b>	
<b>2005</b>	
<b>2004</b>	

**Details of any other weight loss measures (including surgical):**

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**PAST MEDICAL HISTORY (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.):**

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**MEDICAL HISTORY**

**Do you have any of the following conditions? (please check)**

<b>Diabetes</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>(complete section below)</b>
<b>Hypertension</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>(complete section below)</b>
<b>Sleep apnea</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>(complete section below)</b>
<b>GERD (reflux disease)</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>(complete section below)</b>
<b>Cancer</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>(complete section below)</b>
<b>Arthritis</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Joint pain</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Urinary incontinence</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Elevated cholesterol</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Anemia</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Osteoporosis</b>	_____ <b>No</b>	_____ <b>Yes</b>	

**DIABETES – If you have been diagnosed with or treated for diabetes, please complete the following section:**

<b>Juvenile onset</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>Year diagnosed</b> _____
<b>Adult onset</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>Year diagnosed</b> _____

**Current form of control:**

<b>Diet control only</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Oral hypoglycemics</b>	_____ <b>No</b>	_____ <b>Yes</b>	
<b>Insulin</b>	_____ <b>No</b>	_____ <b>Yes</b>	<b>Number of injections per day</b> _____

**Do you have glycosylated hemoglobin (HBA1C) levels tested?** \_\_\_\_\_ **No** \_\_\_\_\_ **Yes**  
**If yes, what is your level (if you know)** \_\_\_\_\_

**HYPERTENSION – If you have hypertension, please complete the following section:**

How long have you had hypertension? \_\_\_\_\_

Are you taking medication for hypertension? \_\_\_\_\_ No \_\_\_\_\_ Yes

**SLEEP APNEA – If you have sleep apnea, please complete the following section:**

When were you diagnosed with sleep apnea? \_\_\_\_\_

Do you use C-Pap? \_\_\_\_\_ No \_\_\_\_\_ Yes (what settings?) \_\_\_\_\_

Do you use Bi-Pap? \_\_\_\_\_ No \_\_\_\_\_ Yes (what settings?) \_\_\_\_\_

**GERD – If you have GERD, please complete the following section:**

Do you have reflux during the day? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, how often?

Many times per day \_\_\_\_\_ Every day \_\_\_\_\_ Most days \_\_\_\_\_ Most weeks \_\_\_\_\_ Occasionally \_\_\_\_\_

Do you suffer from heartburn/indigestion during the night? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, how often?

Many times per day \_\_\_\_\_ Every day \_\_\_\_\_ Most days \_\_\_\_\_ Most weeks \_\_\_\_\_ Occasionally \_\_\_\_\_

Does food or fluid reflux in the mouth? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you vomit with reflux? \_\_\_\_\_ No \_\_\_\_\_ Yes

Treatments you may use for reflux, heartburn, or indigestion, either prescribed or over the counter. (check all that apply)

Zantac \_\_\_\_\_ Tagamet \_\_\_\_\_ Pepcid \_\_\_\_\_ Prevacid \_\_\_\_\_

Nexium \_\_\_\_\_ Prilosec \_\_\_\_\_ Surgery \_\_\_\_\_

**CANCER – If you have been treated for cancer, please check all that apply:**

Breast \_\_\_\_\_ Endometrial \_\_\_\_\_ Prostate \_\_\_\_\_ Colon \_\_\_\_\_  
Thyroid \_\_\_\_\_ Skin \_\_\_\_\_ Blood \_\_\_\_\_ Other (name) \_\_\_\_\_

Year diagnosed \_\_\_\_\_ Cancer-free for \_\_\_\_\_ years

Treatment (check all that apply):

Surgery \_\_\_\_\_ Chemotherapy \_\_\_\_\_ Radiation \_\_\_\_\_ Medication \_\_\_\_\_

**PAST SURGICAL HISTORY:**

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Any problems with anesthesia?       No       Yes

If yes, please describe: \_\_\_\_\_

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Have you had a previous blood transfusion?       No       Yes

If yes, date \_\_\_\_\_ reason \_\_\_\_\_

Have you had a transfusion reaction?       No       Yes

If yes, please describe: \_\_\_\_\_

Will you accept blood products in an emergency?       No       Yes

**CURRENT MEDICATIONS**

Drug	Dose	Frequency

Drug	Dose	Frequency

**ALLERGIES AND ADVERSE REACTIONS (include x-ray dye, antibiotics, skin preps, latex, pain medications, if applicable):**

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**Latex allergy screening questionnaire:**

**Do you have an allergy to any latex products?**                     No                     Yes

**Have you experienced local swelling, itching, or dermatitis associated with latex contact?**                     No                     Yes

**Do you have a history of wheel or blister formation on contact with latex products?**                     No                     Yes

**Have you had an allergic reaction to tape?**                     No                     Yes

**Have you had any food allergies?**                     No                     Yes

**If yes, list here:** \_\_\_\_\_

**FAMILY HISTORY**

	<b>Alive or Deceased</b>	<b>Age</b>	<b>Health Problems and/or Cause of Death</b>
<b>Father</b>			
<b>Mother</b>			
<b>Sibling</b>			
<b>Sibling</b>			
<b>Sibling</b>			

**Is there a family history of morbid obesity?** \_\_\_\_\_

**SOCIAL HISTORY (check all that apply)**

**Marital Status:**

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced since \_\_\_ \_\_\_ Widowed since \_\_\_

**Number of children:** \_\_\_\_\_

**Living Will:** \_\_\_ No \_\_\_ Yes

**Tobacco use:**

\_\_\_ None  
\_\_\_ Currently smoke \_\_\_ PPD for \_\_\_ years  
\_\_\_ Previously smoked \_\_\_ PPD for \_\_\_ years, stopped in \_\_\_  
\_\_\_ Smokeless tobacco

**Alcohol:** \_\_\_ None \_\_\_ Minimal \_\_\_ Moderate \_\_\_ Heavy \_\_\_ Previously heavy

**Caffeine:** \_\_\_ None \_\_\_ Minimal \_\_\_ Moderate \_\_\_ Heavy

**Drug Use:** \_\_\_ Marijuana \_\_\_ Cocaine \_\_\_ Crack \_\_\_ Heroin  
\_\_\_ Other (please list): \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**If you are unemployed, how long?** \_\_\_\_\_

**What is the reason?**

\_\_\_ Physically unable to work \_\_\_ Emotionally unable to work  
\_\_\_ Lack of available jobs in the field \_\_\_ Lack of skills  
\_\_\_ Appearance inappropriate for position sought

**Are you currently disabled or on disability?** \_\_\_ No \_\_\_ Yes

**If so, how long?** \_\_\_\_\_

**Education:**

\_\_\_ 8<sup>th</sup> grade or less \_\_\_ High school graduate \_\_\_ College graduate  
\_\_\_ Some high school \_\_\_ Some college \_\_\_ Post graduate work



**Pulmonary**

Do you have any history of severe emphysema?	_____ No	_____ Yes
Do you have any history of severe bronchitis?	_____ No	_____ Yes
Do you have any history of severe COPD?	_____ No	_____ Yes
Do you have asthma?		
Are you being treated for pneumonia or bronchitis now?	_____ No	_____ Yes
Have you had any wheezing recently?	_____ No	_____ Yes
Do you have shortness of breath at rest?	_____ No	_____ Yes
Do you have shortness of breath on exertion?	_____ No	_____ Yes
Do you have a history of pulmonary embolism?	_____ No	_____ Yes

**Gastrointestinal**

Do you have any liver disease?	_____ No	_____ Yes
Have you had any yellow color to your eyes/skin?	_____ No	_____ Yes
Have you had trouble with your gallbladder?	_____ No	_____ Yes
Have you had any changes in bowel movements?	_____ No	_____ Yes
Have you had any abdominal pain recently?	_____ No	_____ Yes
Have you had any rectal bleeding recently?	_____ No	_____ Yes

**Vascular**

Have you had a previous amputation?	_____ No	_____ Yes
Have you had bypass surgery in a leg?	_____ No	_____ Yes
Do you have pain in your legs at rest?	_____ No	_____ Yes
Are you on dialysis for renal failure?	_____ No	_____ Yes
Have you ever had a deep venous thrombosis (DVT)?	_____ No	_____ Yes

**Musculoskeletal**

Do you have any bone or joint problems?	_____ No	_____ Yes
Do you have any muscle weakness?	_____ No	_____ Yes
Do you have any muscle pain?	_____ No	_____ Yes
Do you have arthritis?	_____ No	_____ Yes
Do you have chronic back problems?	_____ No	_____ Yes
Do you have fibromyalgia?	_____ No	_____ Yes
Do you have swollen ankles?	_____ No	_____ Yes
Do you have varicose veins?	_____ No	_____ Yes

**Central Nervous System**

Do you have any paralysis or partial paralysis of legs/arms?	_____ No	_____ Yes
Do you have a history of TIA's or mini-strokes?	_____ No	_____ Yes
Do you have any history of CVA (stroke)?	_____ No	_____ Yes
Do you have any history of dizziness?	_____ No	_____ Yes
Do you have any history of loss of consciousness?	_____ No	_____ Yes
Do you have any history of seizures?	_____ No	_____ Yes

**Skin**

Do you have rashes? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have psoriasis? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have non-healing lesions? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of melanoma? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of other skin cancers? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Emotional**

Do you have anxiety? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have depression? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Are you undergoing psychiatric therapy? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Endocrine**

Do you have any history of thyroid disorder? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of heat or cold intolerance? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Are you taking thyroid medication? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of diabetes? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Are you on oral medication or insulin for diabetes? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have excessive thirst, hunger, or urination? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of an adrenal disorder? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of a pituitary disorder? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Hematologic/Lymphatic**

Do you have any history of anemia? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you bruise easily? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of excessive bleeding? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Have you had a blood transfusion in the last six months? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of swollen glands? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of leukemia or lymphoma? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have sickle cell? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Are you on medication for anti-coagulation? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Infectious**

Are you HIV positive? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of hepatitis? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If yes, what type? \_\_\_\_\_ A \_\_\_\_\_ B \_\_\_\_\_ C  
Do you have any history of staph infection? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any history of MRSA or ORSA? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Breasts**

Do you have a current breast mass? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have any nipple discharge? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have a personal history of breast cancer? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Do you have a current abnormal mammogram or sonogram? \_\_\_\_\_ No \_\_\_\_\_ Yes  
When was your last mammogram? \_\_\_\_\_  
Are you overdue for mammogram? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Have you had breast augmentation? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Miscellaneous**

Do you wear glasses? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Do you wear contacts? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Do you have regular dental check-ups? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Have you previously had dental surgery? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Do you wear dentures? \_\_\_\_\_ No \_\_\_\_\_ Yes  
     If yes, please check: \_\_\_\_\_ Upper \_\_\_\_\_ Lower  
 Do you have missing teeth? \_\_\_\_\_ No \_\_\_\_\_ Yes  
     If yes, how many ? \_\_\_\_\_  
 Do you have any open wounds? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Are you on any steroid medicine? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Have you lost weight in the past six months? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Have you had any chemotherapy in the past 30 days? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Have you had any radiation in the past 90 days? \_\_\_\_\_ No \_\_\_\_\_ Yes

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations? This survey refers to your usual way of life today. Even if you have not done some of these things recently, try to imagine how you would have been affected. Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

	SCORE
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. movie theater)	
As a passenger in a car for an hour with no break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch with alcohol	
Sitting quietly after lunch with no alcohol	
In a car, while stopped for a few minutes in traffic	
<b>TOTAL</b>	

I attended the Baptist Center for Bariatrics informational seminar on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Patient's signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

You may wish for Baptist Center for Bariatrics to discuss your confidential information with others (such as spouse, partner, family member, etc.). We need your permission to do this.

\_\_\_\_\_ I DO NOT authorize Baptist Center for Bariatrics to discuss my confidential information.

\_\_\_\_\_ I DO authorize Baptist Center for Bariatrics to discuss my confidential information with:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient's signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**PLEASE COMPLETE THIS FORM AND EITHER BRING IT TO YOUR STEP 2 OFFICE VISIT OR RETURN IT PRIOR TO YOUR VISIT BY FAX OR MAIL:**

**Fax**

904.391.5451

**Mail**

Audrey Gomez, Baptist Center for Bariatrics  
Heart Hospital 2<sup>nd</sup> Floor, Wellness Center  
800 Prudential Drive  
Jacksonville, Florida 32207

**Questions? Call 904.202.7546**