



New Bariatric Patient Medical History Form

Name: (First) _____ (Last) _____ (MI) _____
Date of Birth: _____ / _____ / _____ Date of Visit: _____ / _____ / _____
Phone (Home / Cell) _____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight affect your life and health? _____

Weight History:

When did you become overweight?

- Childhood Teens Adulthood Pregnancy Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____

As best you can remember, how much did you weigh one year ago? _____ Five years ago? _____ Ten years ago? _____

Triggers for your weight gain (check all that apply):

- Stress Marriage Divorce Illness Medication abuse Travel Injury
 Night shift work Insomnia Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):

- Weight Watchers Nutrisystem Jenny Craig LA Weight Loss Atkins
 South Beach Zone diet Medifast Dash diet Paleo diet
 HCG diet Mediterranean diet Ornish diet Other: _____

What was your maximum weight loss? _____

What are your greatest challenges with dieting? _____

Have you ever taken medication to lose weight? (check all that apply):

- Phentermine (Adipex) Meridia Xenecal/Alli Phen/Fen
 Phendimetrazine (Bontril) Topamax Saxenda Diethylpropion
 Bupropion (Wellbutrin) Belviq Qsymia Contrave
 Other: _____

What worked? _____

What didn't work? _____

Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____: _____ a.m.

Number of times you eat per day: _____ Do you get up at night to eat? Y / N If so, how often? _____ times

Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____

Sweet beverages (check all that apply):

- Soda Juice Sweet tea Coffee / tea If so, how many times per day? _____



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Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____

Eating triggers (check all that apply):

- Stress Boredom Anger Seeking Reward Parties Eating Out
 Fast Food Other: _____

Food cravings:

- Sugar Chocolate Starches Salty High Fat Large Portions

Favorite foods: _____

Medical History

Exercise type: _____

Duration: ____ hours ____ minutes Number of times per week: ____

What prevents you from exercising? _____

How many hours do you sleep per night? ____

How many times do you get up during the night? ____

Do you feel rested in the morning? ____

Past medical history (check all that apply):

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Angina | <input type="checkbox"/> Gall bladder stones | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Indigestion/reflux arthritis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Gout | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Syndrome | | |

Cancer (type/s): _____

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

- Gastric bypass Gastric banding Gastric sleeve Gall bladder Heart bypass
 Hysterectomy Other: _____

Medications (list all current medications and dosages):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

(Medications): _____

(Foods): _____

Social History:

Smoking: Never Current smoker (____ packs per day) Past smoker (quit ____ years ago)

Alcohol: Never Occasional Regularly (____ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: Never Current Past Type of drugs: _____

Marijuana: Never Current user (____ times per day)

Family History:

Obesity (check all that apply): Mother Father Sister Brother Daughter Son
 Diabetes (check all that apply): Mother Father Sister Brother Daughter Son
 Other (check all that apply): High blood pressure Heart disease Heart disease High cholesterol
 High triglycerides Stroke Thyroid problems Anxiety Depression Bipolar disorder
 Alcoholism Cancer (type/s): _____
 Other: _____

Gynecologic History

Age periods started? _____ Age periods ended? _____ Periods are: Regular / Irregular Heavy / Normal / Light
 Number of pregnancies: _____ Number of children: _____
 Age of first pregnancy: _____ Age of last pregnancy: _____

System Review (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Recent weight loss, more than 10 pounds | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Recent weight gain, more than 10 pounds | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fainting/blacking out | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Difficulty breathing when flat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Food intolerance |
| <input type="checkbox"/> Swelling of ankles/extremities | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Dysphagia/difficulty swallowing | <input type="checkbox"/> Urinary frequency/urgency | <input type="checkbox"/> Slow urine flow |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Loss of urine control | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Gas and bloating | <input type="checkbox"/> Back pain (lower) | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Night time urination | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Back pain (upper) | <input type="checkbox"/> Weakness/low energy | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Muscle aches/pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Inability to concentrate | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Loss of interest | | |
| <input type="checkbox"/> Hair changes | | |
| <input type="checkbox"/> Fatigue/tiredness | | |

(Men only):

- | | | |
|--|--|---|
| <input type="checkbox"/> Difficulty with erections | <input type="checkbox"/> Loss of interest in sex | <input type="checkbox"/> Low testosterone |
|--|--|---|

(Women only):

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Absence of periods | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Change in bladder habits |
| <input type="checkbox"/> Abnormal/excessive menstruation | <input type="checkbox"/> Facial hair | <input type="checkbox"/> Loss of interest in sex |
| <input type="checkbox"/> Difficulty getting pregnant | | |

Comments: _____

