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Bariatric and Metabolic Institute
New Patient Packet

First, Middle, Last name: _____

Gender: Male / Female Date of Birth: _____ Preferred Name: _____

Social Security Number: _____- ____- _____ Age: _____ Ethnicity: _____

Mailing Address: _____

City: _____State: _____ Zip Code: _____

County: _____Primary Care Physician's Name: _____

Email address_____

(_____) _____ - _____ (_____) _____ - _____

Home Phone Number Mobile Phone Number

Pharmacy Name: _____ City: _____

Pharmacy Telephone: _____ Pharmacy Fax Number: _____

Employment Information:

Employer: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

How did you hear about us?

Mark all that apply.

☐Magazine ☐Internet Search ☐Website ☐Television ☐Radio ☐Flyers

☐Friend / Previous Patient (Please tell us who.): _____

☐Physician (Please tell us who): _____

Other: _____

Weight History:

Your Heaviest weight: _____ Number of years of obesity: _____

Eating Habits:

High volume eater: Yes / No Sweets or high calorie eater: Yes / No

Often eat fast foods : Yes / No Guilty of frequent snacking: Yes / No

Emotional Eating : Yes / No Eat when stressed: Yes / No

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Favorite Foods: _____

Food Dislikes: _____

Food Allergies: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snacks: _____

Typical Beverages: _____

Diet Attempts:

Last attempt to reduce calories: _____ Longest duration of diet attempt: _____

Mark all following diets attempted in past: ☐Atkins ☐Beach Body ☐Jenny Craig ☐Low Fat ☐Low Carb ☐Slim Fast ☐Nutrisystem ☐South Beach ☐Optifast ☐Calorie Counting ☐Other: _____

Do you drink caffeine every day? Yes / No How many caffeinated drinks do you drink per day? _____

Do you drink carbonated drinks every day? Yes / No How many carbonated drinks to you drink per day? _____

Have you ever taken prescription weight loss medications? ☐ Yes ☐ No (Examples: Adipex, Saxenda, Phentermine, Alli) Please list the name of the medication and the date you took it.

1. _____ 2. _____

3. _____ 4. _____

Exercise History:

Routine, scheduled exercise: Yes / No Session Length: _____ Number of times per week? _____

Are you a member of a gym: Yes / No If yes, which one? _____

Are you able to walk unassisted: Yes / No

Cardiovascular activities: _____

Strength building activities: _____

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Review of Systems & General Medical Conditions (Mark all that apply to you.)

Neurological:

- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Depression
- ☐ Seizures
- ☐ Memory Loss/Dementia

Respiratory:

- ☐ Shortness of Breath w/Activity
- ☐ Shortness of Breath Lying Flat
- ☐ Chronic Wheezing
- ☐ Chronic Coughing
- ☐ Chronic Emphysema
- ☐ Chronic Bronchitis
- ☐ Coughing Blood
- ☐ COPD
- ☐ Sleep Apnea with Machine Use
  - ☐ BIPAP
  - ☐ CPAP
  - ☐ OTHER
- ☐ Sleep Apnea without Machine Use
- ☐ Asthma

Cardiac:

- ☐ Chest pains
- ☐ Palpations
- ☐ Swollen Feet
- ☐ Cardiac Cath- Date: _____
- ☐ Cardiac Stress Test- Date: _____

Gastrointestinal:

- ☐ Gastroesophageal Reflux Disease
- ☐ Regurgitation
- ☐ Heart Burn
- ☐ Difficulty Swallowing
- ☐ Barrett's Esophagus
- ☐ Abdominal Pain
  - ☐ RUQ
  - ☐ RLQ
  - ☐ LUQ
  - ☐ LLQ
  - ☐ Epigastric
  - ☐ Generalized
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Early feeling of fullness
- ☐ History of Gallstones
- ☐ Gastroparesis
- ☐ Delayed Gastric Emptying
- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ History of Colon Cancer
- ☐ Fatty Liver Disease
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Abnormal Stool Habits: _____

Musculoskeletal

- ☐ Back Pain
- ☐ Knee Pain- R or L
- ☐ Ankle Pain- R or L
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
  - ☐ I am taking immunosuppressants for RA

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Circulatory/Endocrine:

- ☐ Non-Insulin-Dependent Diabetes Mellitis (Type 2)
- ☐ Insulin-Dependent Diabetes Mellitis (Type 1)
- ☐ Congestive Heart Failure
- ☐ Hypertension Benign
- ☐ Hypertension Essential
- ☐ Coronary Heart Disease
- ☐ Venous Insufficiency
- ☐ Slow to heal after cuts
- ☐ Anemia (Iron Deficiency)
- ☐ Pernicious Anemia
  - ☐ B-12
  - ☐ Folate
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Past Transfusion- Date: _____

Vitamin Deficiencies

- ☐ Vitamin B-12
- ☐ Vitamin D
- ☐ Folate Deficiency

Genitourinary

- ☐ PCOS
- ☐ Dysmennorhea
- ☐ Urinary Incontinence
- ☐ Painful Urination
- ☐ Infertility
- ☐ Chronic Kidney Disease
- ☐ Renal Insufficiency

Other:_____

_____

Have you ever been diagnosed with Cancer? ☐ Yes ☐ No

- ☐ Breast
- ☐ Prostate
- ☐ Colon
- ☐ Thyroid
- ☐ Other: _____

Previous Procedures/Surgeries (Mark all that apply to you.)

- ☐ Gastric Bypass (Open)
- ☐ Gastric Bypass (Laparoscopic)
- ☐ Sleeve Gastrectomy (Open)
- ☐ Sleeve Gastrectomy (Laparoscopic)
- ☐ Nissen Fundoplication or Toupe (Open)
- ☐ Nissen Fundoplication or Toupe (Laparoscopic)
- ☐ Vertical Banded Gastroplasty (Open)
- ☐ Vertical Banded Gastroplasty (Laparoscopic)
- ☐ Laparoscopic Adjustable Band
- ☐ Intragastric Balloon
- ☐ Hiatal Hernia Repair (Open)
- ☐ Hiatal Hernia Repair (Laparoscopic)
- ☐ Gastric Restriction surgery(Open)
- ☐ Gastric Restriction surgery (Laparoscopic)

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- ☐ Other Stomach Surgery (Open)
- ☐ Other Stomach Surgery (Laparoscopic)
- ☐ Gallbladder Removal (Open)
- ☐ Gallbladder Removal (Laparoscopic)
- ☐ Umbilical Hernia Repair (Open)
- ☐ Umbilical Hernia Repair (Laparoscopic)
- ☐ Incisional Hernia Repair (Open)
- ☐ Incisional Hernia Repair (Laparoscopic)
- ☐ Inguinal Hernia Repair (Open)
- ☐ Inguinal Hernia Repair (Laparoscopic)
- ☐ Appendectomy (Open)
- ☐ Appendectomy (Laparoscopic)
- ☐ Colectomy (Open)
- ☐ Colectomy (Laparoscopic)
- ☐ Hysterectomy (Open)
- ☐ Hysterectomy (Laparoscopic)
- ☐ Hysterectomy (Vaginal)
- ☐ Pacemaker/Cardiac Stents
- ☐ Cardiac Ablation
- ☐ CABG (Coronary Bypass)
- ☐ Kidney Surgery (Open)
- ☐ Kidney Surgery (Laparoscopic)
- ☐ Knee Surgery (Open)
- ☐ Knee Surgery (Laparoscopic)
- ☐ EGD- When? _____
- ☐ Colonoscopy- When? _____

Other:

_____

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Medication List and Dosage

Do you use any of these medications?

☐ **Plavix** ☐ **Eliquis** ☐ **Coumadin/Warfarin** ☐ **Aspirin** ☐ **Brilinta**

☐ **Phentermine** ☐ **Adderall** ☐ **Other Stimulant for ADHD**

Please list ALL medications you use along with the dosage.

1._____ 9. _____
2. _____ 10._____
3. _____ 11._____
4. _____ 12._____
5. _____ 13._____
6. _____ 14._____
7. _____ 15._____
8. _____ 16._____

Drug Allergies: ☐ **Yes** ☐ **No** **(If yes, please list)**

1._____ 3._____
2. _____ 4. _____

Do you have a Latex Allergy? ☐ **Yes** ☐ **No**

Family Medical History: (Please list any medical diagnoses or conditions)

Father: _____

Mother: _____

Siblings: _____

Children: _____

Social History:

Do you smoke cigarettes, cigars, or pipes? ☐Yes ☐ No If so, number of packs per day: _____

For how many years: _____ Are you a former smoker? ☐Yes ☐No When did you quit? _____

Are you using anti-smoking medicines or patch? ☐Yes ☐No Do you use chewing tobacco or dip? ☐Yes ☐No

Do you Vape? ☐ Yes ☐No If so, how often? _____

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Do you drink alcohol? □Yes □No If so, how often? _____

Have you gone to rehab for alcohol abuse? □Yes □ No

Have you ever used illicit drugs? □ Yes □ No

If so, which drugs & for how long? _____

Have you gone to rehab for drug abuse? □ Yes □ No

Do you use CBD or Medical Marijuana? □Yes □No If so, how often and why?

_____

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How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your recent usual way of life. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

	(0) Never	(1) Slight Chance	(2) Moderate Chance	(3) High Chance
Sitting & Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive in a public place (theater, meeting, etc.)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting & talking with someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Score _____

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During the last month, on how many occasions have you done or been told you do the following? Please check only one box per question.

	(0) Never	(1) Rarely (less than once a week)	(2) Sometimes (1-2 times per week)	(3) Frequently (3-4 times per week)	(4) Always (5-7- times per week)	Do not know
1. Loud snoring	☐	☐	☐	☐	☐	☐
2. Any snoring	☐	☐	☐	☐	☐	☐
3. Your legs feel jumpy or jerky	☐	☐	☐	☐	☐	☐
4. Difficulty falling asleep	☐	☐	☐	☐	☐	☐
5. Frequent awakenings	☐	☐	☐	☐	☐	☐
6. Snorting or gasping	☐	☐	☐	☐	☐	☐
7. Falling asleep when at work	☐	☐	☐	☐	☐	☐
8. Frequent tossing, turning, or thrashing	☐	☐	☐	☐	☐	☐
9. Your breathing stops, or you choke or struggle for breath	☐	☐	☐	☐	☐	☐
10. Excessive sleepiness	☐	☐	☐	☐	☐	☐
11. Morning headaches	☐	☐	☐	☐	☐	☐
12. Falling asleep while driving	☐	☐	☐	☐	☐	☐
13. Feeling paralyzed, unable to move for short periods when falling asleep or awakening	☐	☐	☐	☐	☐	☐
14. Find yourself in a vivid dreamlike state when falling asleep or awakening even though you know you are awake	☐	☐	☐	☐	☐	☐

Score _____