Rex Surgical Specialist (Bariatric Office)

Medical History Information

Today's Date_____

Name_____DOB_____
__

Referring Physician_____ Office phone_____

Primary Care Physician_____ Office phone_____

Medical History (Please Mark all that apply)

❑ Acid Reflux/Heart Burn
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Bipolar disorder
❑ Blood Clots/Bleeding Disorders
❑ Cancer (type)_____
❑ CHF
❑ Chronic Constipation
❑ Chronic Diarrhea
❑ Cirrhosis
❑ COPD
❑ Depression
❑ Diabetes
❑ Diverticulitis
❑ Epilepsy
❑ Ulcers
❑ Fibromyalgia
❑ Gallstones/gallbladder disease
❑ Gout
❑ Heart Disease
❑ Heart Attack
❑ Hepatitis
❑ High Blood Cholesterol
❑ HIV/AIDS
❑ Hypothyroidism
❑ Kidney Disease
❑ Lung disease
❑ Pancreatitis
❑ Pseudotumor Cerebri
❑ Reflux
❑ Sleep Apnea
❑ Stroke
❑ Thyroid disease/Goiter

Please list any other health conditions that were not listed.

_____
_____
_____

_____
_____

Surgical History (Please mark all that apply)

❑ Appendectomy

❑ Brain Surgery

❑ Breast Surgery

❑ Colon Surgery

❑ C-section

❑ Cosmetic Surgery

❑ Stent Placement

❑ Defibrillator

❑ Small Intestine surgery

❑ Valve replacement

❑ Joint replacement:

❑ Eye surgery

❑ Fracture Repair

❑ Gallbladder surgery

❑ Open heart Surgery

❑ Hernia Surgery

❑ Hysterectomy

❑ Pacemaker

❑ Prostate surgery

❑ Spine surgery

❑ Vasectomy

Type_____

❑ Previous bariatric surgery
Type_____

Other surgeries not listed:
_____

Allergies (Please list all allergies and reactions)

1._____4._____
_____

2._____5._____
_____

3._____6._____
_____

Pharmacy

Name_____Address_____
_____

Current Medications (Please list name of medication, Dose, and amount you take daily)

1._____7._____
_____

2._____8._____
_____

3._____9._____
_____

4._____10._____
_____

5._____11._____
_____

6._____12._____
_____

Family History

Relationship	Alive/ Deceased	Birth defects	Breast cancer	Clotting disorder	COPD	Heart disease	Hypertension	Kidney disease	Diabetes
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

Social History

1. Current Nicotine use:

❑ Yes ❑ No

Type of nicotine:_____

How much per day?_____

2. Have you previously used nicotine? ❑ Yes ❑ No

Type_____

When did you quit? _____

3. Current Alcohol Use: ❑ Yes ❑ No

How often?_____

How much?_____ _____

Type of alcohol?_____

4. Current Drug Use: ❑ Yes ❑ No

Type of Drug:_____

How Often?_____

Domestic Abuse

1. Is abuse, violence, or sexual assault a problem for you in any way? ❑ Yes ❑ No
2. Does your partner/caregiver threaten you in any way? ❑ Yes ❑ No

System Review

In the past month, have you had any of the following problems?

GENERAL	NERVOUS SYSTEM	KIDNEY/URINE/BLADDER
❑ Recent weight gain; how much____	❑ Headaches	❑ Frequent or painful urination
❑ Recent weight loss: how much____	❑ Dizziness	❑ Blood in urine

❑ Fatigue

❑ Weakness

❑ Fever

❑ Night sweats

❑ Fainting or loss of consciousness

❑ Numbness or tingling

❑ Memory loss

MUSCLE/JOINTS/BONES

❑ Numbness

❑ Joint pain

❑ Muscle weakness

❑ Joint swelling

Where?

EYES

❑ Pain

❑ Redness

❑ Loss of vision

❑ Double or blurred vision

❑ Dryness

THROAT

❑ Frequent sore throats

❑ Hoarseness

❑ Difficulty in swallowing

❑ Pain in jaw

OTHER PROBLEMS:_____

_____

_____

_____

_____

_____

_____

_

STOMACH AND INTESTINES

❑ Nausea

❑ Heartburn

❑ Stomach pain

❑ Vomiting

❑ Yellow jaundice

❑ Increasing constipation

❑ Persistent diarrhea

❑ Blood in stools

❑ Black stools

HEART AND LUNGS

❑ Chest pain

❑ Palpitations

❑ Fainting

❑ Swollen legs or feet

❑ Cough

EARS

❑ Ringing in ears

❑ Loss of hearing

SKIN

❑ Redness

❑ Rash

❑ Nodules/bumps

❑ Hair loss

❑ Color changes of hands or feet

BLOOD

❑ Anemia

❑ Clots

KIDNEY/URINE/BLADDER

❑ Frequent or painful urination

❑ Blood in urine

Sleep Behavior Information

1. My main sleep complaint is:

❑ I have trouble sleeping at night

❑ I am sleepy all day

❑ I have unwanted behaviors during sleep

❑ I do not have any complaints

2. Sleep habits:

On weekdays, I usually go to bed at _____AM/PM

On weekdays, I usually wake up at _____AM/PM

On weekends, I usually go to bed at _____AM/PM

On weekends, I usually wake up at _____AM/PM

I take a nap about _____days a week

The number of times I wake up during the night_____

It typically takes me _____ minutes or _____ hours to fall asleep

3. Sleep behaviors: Please mark all that apply

❑ I have sometimes fallen asleep at inappropriate times such as driving, eating, or during a conversation.

❑ I have had an accident or near accident when driving because I felt sleepy.

❑ I have been told that I snore loudly.

❑I sometimes awaken with a choking sensation.

❑ I have been told that I stop breathing when I sleep.

❑ I have been told that I grind my teeth at night.

❑ I sometimes wake up with a headache.

❑ I have trouble falling asleep at night.

❑ When I wake up during the night, I have trouble going back to sleep.

❑ I wake up too early in the morning.

❑ Some nights I never get to sleep no matter how hard I try.

❑ Pain often keeps me awake or keeps me from falling back to sleep.

❑ I have a job that involves shift changes or night work.

❑ As an adult I have been noted sleep walking

❑ As an adult I have been heard sleep talking

❑ My dreams are often very vivid

❑ I have fallen out of bed.

❑ I have been told that I have seizures.

❑ I am unable to sleep in a flat position because I become short of breath

❑ I have been told that I act out my dreams.

❑ I have injured myself in my sleep.

❑ I go to the bathroom frequently during the night.

❑ I wet the bed.

❑ I have been told that my legs twitch or jerk while I am sleeping.

I usually consume caffeinated beverages during the day. How many?_____Type? _____

Sleep Apnea Treatment

1. Are you currently using a dental device for snoring or sleep apnea?

   Type of device_____

2. Have you ever worn a dental device for snoring or sleep apnea?

   Type of device_____

3. Are you currently using CPAP/bi-level therapy?

4. When did you start using CPAP/Bileveltherapy?

_____

5. Have you ever been placed on CPAP/Bilevel therapy?

6. Have you ever had surgery for snoring or sleep apnea?

_____

Epworth Sleepiness Scale

How likely are you to doze or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	
2. Watching TV	
3. Sitting inactive in a public place (e.g. a theater or a meeting	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. In a car, while stopped for a few minutes in traffic	

Total score (please add up numbers)

Mental Health History

Have you ever been diagnosed with any of the following?

❑ Alcoholism Date quit_____

❑ Anxiety

❑ Bipolar disorder

❑ Depression

❑ Obsessive compulsive disorder

❑ PTSD

❑ Schizophrenia

Other_____
__

1. Have you ever been hospitalized for a psychiatric condition?

   If so then When?_____Reason?
_____

   Where?
_____

2. Are you currently receiving treatment by a psychiatrist for medication management?

   Name of
psychiatrist_____

3. Are you currently receiving counseling from a psychologist?

   Name of psychologist?
_____

4. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating	0	1	2	3

6. Feeling bad about yourself, or that you are a failure, or have let yourself or family down	0	1	2	3
8. Moving or speaking slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
	Add Columns	_____ +	_____ +	_____ =
Total:_____				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult