Beaumont General and Bariatric Surgery

Center of Excellence
BARIATRIC SURGERY

CLINICAL HISTORY FORM

Patient Name: ___________________ ________________ _______ Date: _______________
Last First Middle Initial

HEIGHT & WEIGHT LOSS HISTORY

Height: ___________ Current Weight: ____________

How many years have you been at your present weight? _____________
How long have you been at least 80-100 lbs overweight? _____________
Greatest single weight loss? ____________ How did you do it? ____________________________

PHYSICAL HISTORY & REVIEW OF SYSTEMS

Please check if you have any of the following:

Cardiovascular
____ Cardiac (heart) problems (includes angina, palpitations, chest pain, heaviness)
____ Heart Attack
____ Cardiomyopathy
____ Congestive heart failure
____ Peripheral vascular disease
____ High cholesterol
____ Hypertension

Endocrinology
____ Diabetes insulin dependant
____ Diabetes non-insulin dependant
____ Thyroid disease: (Describe): ____

Gastrointestinal
____ Heartburn (GERD) ____________Controlled with medications? Which Medication? _____________
____ Pain
____ Ulcer
____ Constipation
____ Diarrhea
____ Vomiting
____ Blood/Mucous in stool
____ Inflammatory bowel disease (Crohn's / Ulcerative Colitis)
____ Gallstones
________ ? Past Cholecystectomy When: __________

Genito-Urinary:
____ Recurrent urinary infection
____ Kidney stones
____ Kidney disease
____ Renal/kidney failure (dialysis)
____ Gout
____ Stress incontinence

Hematology/Lymphatic:

____ Anemia
____ Previous DVT (blood clot)
(Describe): ____
____ Easy bruising/bleeding problems
____ Blood thinner use (Coumadin/Plavix)
____ Iron Supplements
____ Lymph node enlargement

Liver Disease or Infectious Disease:

____ Hepatitis (circle: A, B or C) (Describe) : ______________________________
____ HIV positive
____ Liver Disease (Describe): ______________________________

Musculoskeletal:

____ Arthritis circle: Knees Hips Feet Back Other:
____ Back pain
____ Migraine headaches
____ Limited Mobility: circle if use: Cane Walker Amigo
____ History of Traumatic Injury to bones/joints: ______________________________
____ Pain in weight-bearing joints (Describe): ______________________________

Neurological:

____ Numbness or tingling of the feet or hands
____ Seizures
____ Epilepsy
____ Headache

Ob/Gyn:

____ Irregular Periods
____ Infertility
____ Abnormally Painful Periods

Psychological:

____ Depression
____ Bi-Polar disorder
____ Anorexia
____ Suicide attempt
______ Anxiety
______ Bulimia

Respiratory:

Do you currently smoke?____________________ _________ pack per day
Have you smoked in the past? ________ How long since you quit? ______ Previous pack per day _______

____ Asthma
____ Shortness of breath upon exertion
____ COPD (Chronic Obstructive Pulmonary Disease)
____ Emphysema
____ Home Oxygen
____ Sleep Apnea When diagnosed? _________________ Treated with C-Pap/Bi-Pap ____ Yes ____ No
_______ Chronic Cough
_______ Wheezing

Skin:

____ Itching
____ Rashes
____ Dry Skin
____ Psoriasis

MEDICATIONS:

List all medications currently taking on a regular basis:

Do you take aspirin on a regular basis? ____ Yes ____ No

Do you use any type of steroid medication? ____ Yes ____ No

Do you use Birth Control Pills or Hormone Replacement Therapy? ____ Yes ____ No

Current Medication	Dosage	Frequency	Reason for Taking

PAST SURGICAL HISTORY

Operation	Reason	Date

SIGNIFICANT FAMILY HISTORY

List any family members who have sufferance or experienced any of the following conditions: (Include only: Parents, Grandparents, Maternal, Paternal and Siblings)

High Blood Pressure
____

Diabetes
____

Arthritis
____

Heart Disease
____

Stroke ____

Lung Disease
____

Cancer ____

Obesity ____

Early Death
____

DVT/Blood clots
____

PAST MAJOR MEDICAL HISTORY

Major Illness	Date	Treatment

GENERAL HISTORY

Do you drink alcohol? ____ Yes ____ No Frequency: ______________________________

Do you use any drugs? (Non-prescription) ____ Yes ____ No Frequency: ______________________________

ALLERGIES

Are you allergic to any medications? ____ Yes ____ No

Medication	Reaction

Are you allergic to any foods? (Dairy, wheat products, shellfish) ____ Yes ____ No

Food	Reaction

Are you allergic to Latex? ____ Yes ____ No
If yes, what happens?

____

I declare that the above provided information is true to the best of my knowledge, information and belief

Patient Signature: ______________________________ Date: ______________