SUMMIT MEDICAL GROUP

Bariatric Intake Packet

Medical History – Please check if you have or ever had any of the following

☐ Diabetes	☐ Gallstones
☐ Hypertension	☐ Reflux/Heartburn
☐ Obstructive Sleep Apnea	☐ Fatty Liver
☐ High Cholesterol / Hyperlipidemia	☐ Hiatal Hernia
☐ Congestive Heart Failure	☐ Gout
☐ Heart Disease/Coronary Artery Disease	☐ Back pain
☐ Angina	☐ Arthritis
☐ Pulmonary Hypertension	☐ Polycystic Ovarian Disease
☐ Deep Venous Thrombosis	☐ Menstrual Irregularities
☐ Pulmonary Embolus	☐ Fibromyalgia
☐ Asthma	☐ Depression
☐ Peripheral Vascular Disease	☐ Other Mental Illness
☐ Leg Edema	☐ Stress Urinary incontinence

Other medical conditions:

_____

Surgical History – Please list any surgeries that you've had	**Allergies** – Please list all your allergies
☐ Gallbladder removal ☐ Hernia surgery ☐ Anti-reflux surgery ☐ Abdominoplasty ☐ Joint surgery ☐ Urinary incontinence surgery ☐ Hysterectomy Other: _____	_____ _____ _____ _____

Family History – Please check if any relative has/had	**Social History**
☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Obesity ☐ Cancer ☐ Tuberculosis ☐ Bleeding Tendencies ☐ Stroke ☐ Other: _____	**Occupation:** _____ **Do you use Tobacco?** ☐ Yes ☐ No If yes how much:_____ **Do you use Alcohol?** ☐ Yes ☐ No If yes how much: _____ **Do you use any illicit Drugs?** ☐ Yes ☐ No If yes how much: _____

Symptoms – Check symptoms you currently have or have had in the past

GENERAL
- ❑ Chills
- ❑ Fever
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Sweats

Eye, Ear, Nose, Throat
- ❑ Blurred vision
- ❑ Difficulty swallowing
- ❑ Earache
- ❑ Hoarseness
- ❑ Sinusitis

GASTROINTESTINAL
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Indigestion
- ❑ Heartburn
- ❑ Rectal bleeding

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Muscle/Joint/Bone

Pain, weakness, numbness in
- ❑ Arms ❑Hips
- ❑ Neck ❑Legs
- ❑ Back ❑Feet

HEART/LUNG
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Coughing up of blood
- ❑ Inability to breath when lying flat
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Snoring
- ❑ Daytime Sleepiness

Medications – Please list all your current medications

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Medication: _____Dosage: _____How often: _____

Weight History – Please fill out completely

	Normal	Overweight	Obese
Childhood (1-12 y.o.)	☐	☐	☐
Adolescence (13-18 y.o.)	☐	☐	☐
Young Adulthood (19-30 y.o.)	☐	☐	☐
Adulthood (>30 y.o.)	☐	☐	☐

Weight over last 5 years

Current Year _____
1 year ago: _____
2 years ago: _____
3 years ago: _____
4 years ago: _____
5 years ago: _____

The following questions are intended to find out what you already know about surgery for clinically severe obesity. Make sure to complete this form before your scheduled appointment.

1. After surgery, how much food will you be able to eat at one time? _____
2. How much weight do you expect to lose within one year of surgery? _____
3. Can any person who is overweight have weight loss surgery? _____
4. What are the risks of weight loss surgery? _____
5. After losing a enough weight, do you need to have a second surgery to "undo" the weight loss procedure?_____
6. Approximately how long does weight loss surgery take to perform? _____
7. Approximately how long will you be hospitalized after the procedure? _____
8. Is it possible to "out -eat" the effects of weight loss surgery? _____
9. Must you continue to see a doctor regularly after surgery? _____
10. Will you need to make lifestyle changes after surgery? _____
11. At what age did you develop a weight problem? _____

Additional Questions

12. What is the most that you have weighed? _____
13. How much weight do you think you need to lose? _____
14. How does your weight influence your lifestyle? _____
15. How does your weight influence your Health? _____
16. Do you suffer from Depression? If yes, how do you think surgery and its resulting weight loss would affect your depression? _____
17. Do you participate in any exercise activity? if so, what type of exercise do you do? How long do you exercise for? How often do you exercise? _____

Diet History

Program	Year	Weight Lost	Weight Regained	Length of Program	Cost
Weight Watchers					
Richard Simmons					
LA Diet					
Slim fast					
Jenny Craig					
Trim spa					
The Zone					
Sugar Busters					
Atkin's Diet					
South Beach Diet					
Nutri-System					
Opti fast					

TOPS					
Diet Center					
Diet Pills					
Liquid Diets					
Low calorie Diets					
Dietician consult					
Physicians weight loss					
Hypnosis					
Acupuncture					
Jaw Wiring					
Fad Diets(specify)					
Other(specify)					
Gym/Exercise program					