NORTHWEST ALLIED BARIATRIC & FOREGUT SURGERY

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MEDICAL HISTORY INFORMATION

Surgeon: Chiasson or Burpee

Last Name_____ **First Name** _____ **MI** ____

Date of Birth _____ **Gender: Male Female Primary Care:** _____

Race: (For Multi-racial choose all that apply)

- ❑ African American
- ❑ Asian
- ❑ Caucasian
- ❑ Hispanic
- ❑ Native American or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Other

Employment Status:

- ❑ Full Time ❑ Part Time ❑ Self Employed
- ❑ Homemaker
- ❑ Not Specified
- ❑ Student ❑ Retired ❑ Disabled
- ❑ Unemployed

Employer: _____ **Occupation:** _____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed

PREVIOUS BARIATRIC SURGERIES

Have you had a previous bariatric procedure? ❑ YES ❑ NO

If yes: Year _____ Surgeon _____

Original Weight _____ lbs Lowest weight_____lbs

Which procedure?

- ❑ Biliopancreatic diversion (BPD)
- ❑ BPD with duodenal switch Gastrectomy
- ❑ Gastric band, adjustable
- ❑ Gastric band, non-adjustable
- ❑ Gastric bypass (Roux-en-Y), laparoscopic ❑ Gastric bypass (Roux-en-Y), Open
- ❑ Gastric bypass (Roux-en-Y) with distal Gastrectomy, laparoscopic
- ❑ Gastric bypass (Roux-en-Y) with distal Gastrectomy, open
- ❑ Gastric bypass, banded
- ❑ Gastric bypass; mini loop
- ❑ Gastric pacing
- ❑ Intestinal bypass
- ❑ Sleeve gastrectomy
- ❑ Vertical banded gastroplasty
- ❑ Other _____

Did you have complications? ❑ **YES** ❑ **NO** If so, please describe _____

_____

VITAMINS - *Please check any vitamins that you are currently taking.*

- ❑ Multi-Vitamin
- ❑ Vitamin A, D, E Combo
- ❑ Vitamin D
- ❑ Iron
- ❑ Calcium
- ❑ Calcium w/D
- ❑ Vitamin B-12

SURGICAL HISTORY - *Please check all that apply.*

- ❑ Anti-reflux procedure
- ❑ Breast cancer, biopsy
- ❑ CABG
- ❑ Cholecystectomy/Gallbladder Laparoscopic or Open
- ❑ Knee replacement
- ❑ Peripheral vascular procedure
- ❑ Vasectomy
- ❑ Hip replacement
- ❑ Breast cancer, mastectomy
- ❑ Caesarian section
- ❑ Appendectomy Laparoscopic or Open
- ❑ Laminectomy
- ❑ Tubal ligation
- ❑ Other. _____
- ❑ Breast cancer, radiation
- ❑ Bowel resection
- ❑ Discectomy
- ❑ Nissen fundoplication Laparoscopic or Open
- ❑ Hysterectomy (+1- oophorectomy)
- ❑ Vagotomy
- ❑ Other: _____

MEDICAL HISTORY - *Please check all that apply.*

Cardiovascular Disease

- ❑ Hypertension/High Blood Pressure
- ❑ Congestive Heart Failure
- ❑ Ischemic Heart Disease
- ❑ Angina — chest pain
- ❑ Peripheral Vascular Disease
- ❑ Lower Extremity Edema
- ❑ DVT/PE - Blood Clots

Metabolic

- ❑ Glucose Metabolism — Diabetes
- ❑ Gout
- ❑ High Cholesterol/Lipids
- ❑ Thyroid — Hyper or Hypo

Pulmonary

- ❑ Sleep Apnea Syndrome
- ❑ Obesity Hypoventilation Syndrome
- ❑ Pulmonary Hypertension
- ❑ Asthma

Gastrointestinal

- ❑ GERD - Acid Reflux
- ❑ Gallstones
- ❑ Liver Disease

Musculoskeletal

- ❑ Musculoskeletal Disease - Arthritis
- ❑ Back Pain
- ❑ Fibromyalgia

Reproductive

- ❑ Polycystic Ovarian Syndrome
- ❑ Menstrual Irregularities (not PCOS)

Psychosocial

- ❑ Psychosocial Impairment
- ❑ Depression
- ❑ Bipolar disorder
- ❑ Anxiety/panic disorder
- ❑ Personality disorder

General - *Please check all that apply.*

Pseudotumor Cerebri

- ❑ Headaches, no visual symptoms
- ❑ Headaches with visual symptoms
- ❑ Stress Urinary/Incontinence
- ❑ Abdominal Hernia
- ❑ Abdominal Skin/Pannus
- ❑ Blood Transfusion — date _____

Functional Status

- ❑ Requires assistance device to walk
- ❑ Requires wheelchair
- ❑ Bedridden
- ❑ Other: _____
- ❑ Other: _____

- ❑ MRSA

SOCIAL HISTORY

Please check the boxes that apply.

Alcohol use

❑ Never ❑ Rare ❑ Occasional ❑ Frequent

Tobacco Use

❑ Never ❑ Rare ❑ Occasional ❑ Frequent

Substance Abuse (Prescription or Illegal)

❑ Never ❑ Rare ❑ Occasional ❑ Frequent

FAMILY HISTORY

Please list illnesses that affected your parents.

Mother	Father

MEDICATIONS

Please list all prescription and over-the-counter medications you are currently taking and dosage.

Drug	Dosage	Drug	Dosage

Allergies: ☐ No known allergies

Please list type and reaction

Drug	Reaction

Are you allergic to latex or tape? ☐ Yes ☐ No

DIET HISTORY

Age when you first dieted: Total # of weight loss attempts: Ideal weight: lbs

Efforts at supervised weight loss
Note the programs that you have tried. Please complete all *that apply to you.*

PROGRAMS	Dates	MD Supervised	Max Wt Loss
Jenny Craig		Y / N	
Nutri-systems		Y / N	
Weight Watchers		Y / N	
Opti/Medi Fast		Y / N	
Phentermine		Y / N	
Meridia		Y / N	
Lindora		Y / N	
T.O.P.S.		Y / N	
O.A.		Y / N	
Acupuncture		Y / N	
Atkins		Y / N	
South Beach		Y / N	
Other		Y / N	

The above information is true and accurate.

Patient signature

_____

Date

_____

NORTHWEST ALLIED
BARIATRIC & FOREGUT SURGERY

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Name _____

Height_____ Weight _____

Age_____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

REVIEW OF SYSTEMS

Check "yes" for any current illness and/or disease. Check "no" for all others. TODAY'S DATE _____

CONSTITUTIONAL

NO YES
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Malaise
- ☐ ☐ Night sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss

Other: _____

HEENT
- ☐ ☐ Ear drainage
- ☐ ☐ Ear pain
- ☐ ☐ Eye discharge
- ☐ ☐ Eye pain
- ☐ ☐ Hearing loss
- ☐ ☐ Nasal drainage
- ☐ ☐ Sinus pressure
- ☐ ☐ Sore throat
- ☐ ☐ Visual changes

Other: _____

RESPIRATORY
- ☐ ☐ Chronic cough
- ☐ ☐ Cough
- ☐ ☐ TB exposure
- ☐ ☐ Shortness of breath
- ☐ ☐ Wheezing

Other: _____

CARDIOVASCULAR
- ☐ ☐ Chest pain
- ☐ ☐ Claudication (leg weakness with circulation problems)
- ☐ ☐ Edema (swelling)
- ☐ ☐ Palpitations

Other: _____

GASTROINTESTINAL
- ☐ ☐ Abdominal pain
- ☐ ☐ Blood in stools
- ☐ ☐ Change in stools
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Other: _____

GENITOURINARY – FEMALE
- ☐ ☐ Dysuria (difficult/ painful urination)
- ☐ ☐ Hematuria (blood in urine
- ☐ ☐ Polyuria (excessive urination
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary incontinence
- ☐ ☐ Urinary retention

Other: _____

REPRODUCTIVE – FEMALE

NO YES
- ☐ ☐ Abnormal pap
- ☐ ☐ Dysmenorrhea (painfulmenstruation
- ☐ ☐ Dyspareunia (painful intercourse)
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular menses
- ☐ ☐ Vaginal discharge

Other: _____

GENITOURINARY – MALE
- ☐ ☐ Dribbling
- ☐ ☐ Dysuria (difficult/painful urination)
- ☐ ☐ Hematuria (blood in urine
- ☐ ☐ Polyuria (excessive urination
- ☐ ☐ Slow stream
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary incontinence
- ☐ ☐ Urinary retention

Other: _____

REPRODUCTIVE – MALE
- ☐ ☐ Erectile dysfunction
- ☐ ☐ Penile discharge
- ☐ ☐ Sexual dysfunction

Other: _____

INTEGUMENTARY
- ☐ ☐ Breast discharge
- ☐ ☐ Breast lump
- ☐ ☐ Brittle hair
- ☐ ☐ Brittle nails
- ☐ ☐ Hair loss
- ☐ ☐ Hirsutism (excessive body hair
- ☐ ☐ Hives
- ☐ ☐ Pruritus (itching)
- ☐ ☐ Mole changes
- ☐ ☐ Rash
- ☐ ☐ Skin lesión

Other: _____

NEUROLOGICAL
- ☐ ☐ Dizziness
- ☐ ☐ Extremity numbness
- ☐ ☐ Extremity weakness
- ☐ ☐ Gait disturbance
- ☐ ☐ Headache
- ☐ ☐ Memory loss
- ☐ ☐ Seizures
- ☐ ☐ Tremors

Other: _____

PSYCHIATRIC

NO YES
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Insomnia

Other: _____

METABOLIC/ENDOCRINE
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Polydipsia (excessive thirst
- ☐ ☐ Polyphagia (over eating

Other: _____

MUSCULOSKELETAL
- ☐ ☐ Back pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint swelling
- ☐ ☐ Muscle weakness
- ☐ ☐ Neck pain

Other: _____

HEMATOLOGIC
- ☐ ☐ Easy bleeding
- ☐ ☐ Easy bruising
- ☐ ☐ Lymphadenopathy (swelling of lymph nodes)

Other: _____

IMMUNOLOGIC
- ☐ ☐ Contact allergy
- ☐ ☐ Environmental allergies
- ☐ ☐ Food allergies
- ☐ ☐ Seasonal allergies

Other: _____

Colonoscopy:
☐ **Yes** ☐ **No**
Date_____

Mammogram:
☐ **Yes** ☐ **No**
Date_____

PAST TESTS/DIAGNOSTICS/LABS:

DATE	TYPE

Immunizations:

Flu Shot Date: _____
Pneumonia Date: _____
Tetanus Date: _____
Patient Initials _____

Patient Name: _____ **Date of Birth:** _____