

Name: _____ DOB: _____

DATE Past hospitalizations, surgeries, injuries

Any complications after surgery? _____

Any complications with anesthesia/sedation? _____

Present Conditions Requiring Medical Care

Condition	Doctor	Last Visit

List of ALL Medical Providers Over the Past 5 Years (important for insurance documentation)

Name	Specialty	Address	Phone #	Fax #

Reviewed/Updated by:

Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date

Name: _____ DOB: _____

Social History

Gender: Male Female
Employment Status: Full Time Part Time Self Employed Homemaker Student
 Retired Disabled Unemployed Not Specified
Race: (For multi-racial, choose all that apply)
 African American Caucasian Native American or Alaska Native Asian Hispanic
 Native Hawaiian or other Pacific Islander Other
Religion: _____
Alcohol Use: None Rare Occasional Frequent
Tobacco Use: None Rare Occasional Frequent
Substance Abuse: (Prescription or Illegal) None Rare Occasional Frequent
Marital Status: Single Married Separated Divorced Widowed
Number of children _____ Do you live alone? _____ Do you drive? _____

Significant Family History (parents, sisters, brothers, aunts, uncles, grandparents)

Heart _____ Stroke _____
High blood pressure _____ Diabetes _____
Thyroid _____ Lung disease _____
Cancer _____ Bleeding disorders _____
Liver disease _____ Gallbladder _____
Obesity _____

Women Only

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____
Birth control method: _____ Last menstrual period: _____
Last PAP and results: _____ Last Mammo and results: _____

Reviewed/Updated by:

Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date

Name: _____ DOB: _____

Have you ever been diagnosed with, or troubled by, any of the following conditions in the past or present?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> night sweats | <input type="checkbox"/> "pockets" in colon | <input type="checkbox"/> anorexia/bulimia/ eating disorder | <input type="checkbox"/> infertility |
| <input type="checkbox"/> unintended weight loss | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> skin infection | <input type="checkbox"/> polycystic ovaries |
| <input type="checkbox"/> skin condition/rash | <input type="checkbox"/> diarrhea/ constipation | <input type="checkbox"/> sebaceous cysts | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> black/bloody stools | <input type="checkbox"/> cataracts | <input type="checkbox"/> osteoarthritis |
| <input type="checkbox"/> voice changes | <input type="checkbox"/> # of BM's daily _____ | <input type="checkbox"/> glaucoma | <input type="checkbox"/> degenerative joint disease |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> wheezing/asthma | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> dizzy/fainting spells | <input type="checkbox"/> urine infections | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> hearing changes | <input type="checkbox"/> stress urinary incontinence | <input type="checkbox"/> bronchitis/pneumonia | <input type="checkbox"/> carpal tunnel |
| <input type="checkbox"/> emphysema/COPD | <input type="checkbox"/> prostate problems | <input type="checkbox"/> sleep apnea | <input type="checkbox"/> gout |
| <input type="checkbox"/> change in phlegm/sputum | <input type="checkbox"/> blood in urine | <input type="checkbox"/> pulmonary emboli ("clot") | <input type="checkbox"/> herniated discs |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> kidney stones | <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> foot pain |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> postmenopausal | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> broken bones | <input type="checkbox"/> clot in leg/phlebitis | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> artificial joints | <input type="checkbox"/> varicose veins | <input type="checkbox"/> depression |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> chemical dependency | <input type="checkbox"/> angina/chest pain | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> anemia | <input type="checkbox"/> nervousness/phobia | <input type="checkbox"/> venous insufficiency | <input type="checkbox"/> pseudotumor cerebri |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> physical/sexual abuse | <input type="checkbox"/> hernia or recurrent | <input type="checkbox"/> cancer type: _____ |
| <input type="checkbox"/> colitis/Crohn's | <input type="checkbox"/> memory loss | <input type="checkbox"/> heartburn/reflux/GERD | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> hepatitis A B C | <input type="checkbox"/> balance problems | <input type="checkbox"/> gallbladder trouble | <input type="checkbox"/> high lipids |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> fatty liver disease | <input type="checkbox"/> knee pain |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> weakness | <input type="checkbox"/> colon polyps | <input type="checkbox"/> hip pain |
| <input type="checkbox"/> artificial heart valve/stent | <input type="checkbox"/> seizures | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> abnormal EKG |
| <input type="checkbox"/> legs cramp when walking | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> urine leaking | <input type="checkbox"/> respiratory failure |
| <input type="checkbox"/> jaundice | <input type="checkbox"/> thyroid condition | <input type="checkbox"/> menstrual irregularity | <input type="checkbox"/> bipolar |
| <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> pre-eclampsia | <input type="checkbox"/> personality disorder |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> blood transfusions when: _____ | <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> psychosis |
| <input type="checkbox"/> decreased appetite | | <input type="checkbox"/> diabetes | <input type="checkbox"/> ABD rash |
| <input type="checkbox"/> stomach ulcer | | <input type="checkbox"/> hirsutism | <input type="checkbox"/> leg swelling |
| <input type="checkbox"/> abdominal pain | Co-morbid conditions | | <input type="checkbox"/> heart attack/MI |
| | <input type="checkbox"/> chronic fatigue | | <input type="checkbox"/> stroke/TIA |

Notes: _____

Reviewed/Updated by:

Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date

***Please document history and attempts thoroughly and completely.

Name: _____ DOB: _____

Weight Loss History								
Year	200	200	200	200	200	200	200	200
Weight								

Weight Loss Attempts					
√	Weight Loss Method	Approximate Dates	Approximate Weight	Outcome Weight Loss/Gain	Physician Supervised and M.D. name
	TOPS				
	Weight Watchers				
	Overeaters Anonymous				
	Atkins				
	Jenny Craig				
	Nutri-Systems				
	Richard Simmons				
	Slim-Fast				
	Opti-Fast				
	Dexatrim				
	Diet patch				
	Low carbohydrate				
	Herbalife				
	Meridia				
	Xenical				
	Fen-Phen				
	Redux				
	Phenteramine				
	Nutritionist/Dietician				
	Hypnosis				
	Accupressure				
	Psychotherapy				
	Behavior modification				
	Exercise				
	Calorie count				
	Other (list):				

The above information is true and correct to the best of my knowledge.

Patient's Signature: _____ Date: _____

Reviewed/Updated by:

Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date

Name: _____ DOB: _____

Do NOT Write Below This Line – For Doctor’s Use ONLY

=====Physical Exam=====

Height: _____ (inches) Age: _____ BP: _____

Weight: _____ (pounds) Hgt (m)2: _____ Temp: _____

Waist circumference: _____ (cm) BMI: _____ Pulse: _____

Hip circumference: _____ (cm) IBW: _____ Resp: _____

Waist to hip ratio: _____ EBW: _____

General: alert no distress central distribution _____

Skin: warm dry no lesions acanthosis nigricans hirsutism buffalo hump _____

HEENT: hearing & vision intact PER EOMI sclerae white
 pharynx clear mucosa moist _____

Neck: supple nl thyroid no nodes no JVD no bruit _____

Lungs: equal BrS no rales no rhonchi no wheeze _____

Heart: RRR no murmur S1 & S2 _____

Breast: no nipple retraction no dimpling no mass no discharge
 no adenopathy no skin changes _____

Abdomen: scaphoid BS + nontender soft no mass no HSM no hernia
 no pulsation no bruit striae _____

Back: nontender _____

GU: nontender no testicular mass no hernia no discharge _____

Extremities: ambulatory nl ROM no edema no ulcers no clubbing
 no cyanosis nl CPR _____

Circulation	Radial	Brachial	Carotid	Femoral	Popliteal	Post Tib	Dors Ped
Left							
Right							

Rectal: nl tone no mass nl prostate guiac neg _____

Neuro: oriented X 3 CN 2 – 12 intact no gross deficit _____

Name: _____ **DOB:** _____

Lab:

X-Ray:

Impression:

Plan: Presentation viewed

The patient understands the proposed procedure, its indications & alternatives. The patient also understands the inherent risks, benefits & prognosis and gives full consent to proceed with _____ . Risks discussed (but not entirely inclusive of any possible risk): _____

The entire form, including ROS, for today's exam has been reviewed by provider. **Yes** **No**

Patient is being seen in consultation at the request of _____
for bariatric consult and/or _____. A letter is being sent to the requesting provider.

Provider signature: _____ **Date:** _____

Name: _____ DOB: _____

