Attending medically supervised weight loss information session? ◯ Yes ◯ No

Surgical

Information Session Date: _____

BARIATRIC CENTER
AT COLUMBUS REGIONAL HOSPITAL
2325 18TH STREET • COLUMBUS, INDIANA 47201 • (812)375-3972

PATIENT HEALTH INFORMATION

PERSONAL INFORMATION

NAME (Last, First, Middle Initial)	AGE	SEX (M/F)	BIRTHDATE (MM/DD/YY)	SOCIAL SECURITY NUMBER
, ,				

ADDRESS (Street, City, State, Zip Code)

TELEPHONE (patient's)
Can we leave a message at work ◯ Yes ◯ No
Work: _____
Home: _____
Cell Phone _____

Can we share phone/e-mail with support group patients to update you: ◯ Yes ◯ No
E-Mail _____

Name of Person to Notify In Case of Emergency:	**Name & Full Address of Personal Physician:**	Insurance Name:
(Name)		Address:
(Address)		Insurance Telephone Number (with extensions):
(Address 2)	Physician Office Telephone Number	SS#:
Relationship:		
Home Phone Cell Phone		D.O.B.

PERSONAL HISTORY

HEALTH HABITS

A. If you used tobacco products in the past, when did you quit? _____

B. Do you now or have you ever used illegal drugs? ◯ Yes ◯ No Explain _____

C. Do you wear any of the following: ☐ Ortho Braces ☐ Special shoes ☐ Hearing aid(s) ☐ Glasses ☐ Dentures ☐ CPAP/Bipap ☐ Other (specify): _____

D. Are there any barriers that prevent you from exercising or walking after surgery? _____

E. What is your occupation: _____ Do you lift heavy objects in your job? ◯ Yes ◯ No

F. Do you do any heavy lifting? ◯ Yes ◯ No Explain: _____

G. Do you have problems reading or writing beyond the 6th grade level? ◯ Yes ◯ No

HEALTH HISTORY

I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important the physician has complete and accurate information in order to provide safe medical evaluation and care. I understand that this medical history is used in providing care through the Bariatric Center, and that some information may need to share with referring physicians / counselors.

Signed electronically, see attached. _____ _____
Signature Date

As part of The Bariatric Center Program, we will periodically obtain pictures.
I agree that my pictures may be used for statistical / educational purposes.

Signed electronically, see attached. _____ _____
Signature Date

Can we release any records to family members? ◯ Yes ◯ No _____

PATIENT LABEL
OR
Patient Name: _____
DOB: ____/____/____
MR #: _____

ALLERGIES

Do you have any allergies to Drugs, Environmental Agents, Food Agents or Latex?

◯ No Known Allergies ◯ Yes

If Yes, List:

Allergy	Describe Reaction

MEDICATIONS

Please **List All Medications** You Are Currently Taking or Have Taken During the Last 30 Days (including Vitamins, Birth Control Pills, Herbal Medications, etc.) **Include actual dosage and frequency**.

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY
1)			8)		
2)			9)		
3)			10)		
4)			11)		
5)			12)		
6)			13)		
7)			14)		

HOSPITALIZATIONS and SURGERIES

TYPE / REASON	SURGEON	PLACE OF SURGERY	DATE (if known)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PREVIOUS WEIGHT LOSS SURGERY ◯ **Yes** ◯ **No**

Type	Surgeon	Date	Results
1.			
2.			

COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
1-800-841-4938 812-379-4441

Patient Health Information

PATIENT LABEL
OR

Patient Name:_____

DOB:____/____/____

MR #:_____

ILLNESS HISTORY

ILLNESSES - Check YES or NO; If you have currently or have ever had the following conditions / illnesses.

GENERAL

1. Serious infectious disease, tumors/cancer . ○Yes ○No
2. Skin problems / rashes ○Yes ○No
3. Sinus problems, nosebleeds ○Yes ○No
4. Hay fever ○Yes ○No
5. Ear infections ○Yes ○No
6. Eye problems ○Yes ○No
7. Hoarseness ○Yes ○No

RESPIRATORY

8. Asthma / wheezing ○Yes ○No
9. Emphysema ○Yes ○No
10. Pneumonia/Bronchitis ○Yes ○No
11. Cannot breathe lying flat ○Yes ○No
12. Shortness of breath ○Yes ○No
13. Frequent coughs / colds ○Yes ○No
14. Coughing up blood / mucus ○Yes ○No
15. Soaking night sweats ○Yes ○No

CARDIOVASCULAR

16. Heart valve problems ○Yes ○No
17. Chest pain ○Yes ○No
18. Heart attack ○Yes ○No
19. High blood Pressure ○Yes ○No
20. High cholesterol ○Yes ○No
21. Heart murmur ○Yes ○No
22. Varicose veins ○Yes ○No
23. Blood Clots ○Yes ○No
24. Bleeding problems / anemia ○Yes ○No
25. Ever receive a blood transfusion ○Yes ○No
26. Palpitation /Irregular heart rate ○Yes ○No
27. Pacemaker ○Yes ○No
28. Edema / Swelling ○Yes ○No

GASTRO INTESTINAL

29. Ulcers ○Yes ○No
30. Liver or Gallbladder problems ○Yes ○No
31 Bowel irregularities (Diarrhea/Constipation) ○Yes ○No
32. Abdominal Pain ○Yes ○No
33. Frequent heartburn ○Yes ○No
34. Frequent vomiting / nausea ○Yes ○No
35. Bloody stool / urine ○Yes ○No

Urinary

36. Kidney stones ○Yes ○No
37. Frequent urination ○Yes ○No
38. Bladder control problems -- - - - ○Yes ○No
39. Painful urination ●Yes ○No

Muscular

40. Bone / Joint problems ○Yes ○No
41. Back / Neck pain ○Yes ○No
42. Arthritis / Gout ○Yes ○No
43. Knee/Hip surgery ○Yes ○No

NEURO

44. Numbness / tingling in hands or feet ... ○Yes ○No
45. Dizziness ○Yes ○No
46. Stroke ○Yes ○No
47. Seizures ○Yes ○No
48. Sleep Apnea ○Yes ○No

ENDOCRINE

49. Diabetes ○Yes ○No
50. Thyroid Problems ○Yes ○No
51. Tiredness / Fatigue ○Yes ○No

EMOTIONAL

52. Depression or emotional problems ○Yes ○No
53. Anxiety / Stress ○Yes ○No
54. Other _____

Please explain any check from above starting with the number, please identify if this is a current or past problem:

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DOB:____/____/____

MR #: _____

FAMILY HISTORY

Check Correct Box	Father	Mother	Brothers	Sisters	Father's Father	Father's Mother	Mother/s Father	Mother's Mother	Other
Asthma									
Heart Attack									
Cancer									
Diabetes									
Gall Bladder Disease									
High Blood Pressure									
Strokes									
Weight Problems									
Arthritis / Gout									
Seizures									
Problems with Anesthesia									

As Bariatric Patients have a high rate of Sleep Apnea and Blood Clot problems; please complete the Sleep Screening and Blood Clot Risk Factor forms. It is also important that a Weight Loss History be completed for insurance approval.

FOR WOMEN ONLY

Please complete the following:

A. Menstrual Cycle problems ◯Yes ◯No Explain:_____

B Hysterectomy ◯Yes ◯No Date: _____ Tubal Ligation ◯Yes ◯No Date:_____

C. Menopausal ◯Yes ◯No Hot Flashes ◯Yes ◯No

D. Problems having children ◯Yes ◯No Explain:_____

E. Pregnant now ◯Yes ◯No Date of last period: _____

F. Date of last Mammogram:_____Date of last Pap Smear _____

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THROMBOSIS RISK FACTOR

Please read the list of risk factors below, and check all the factors that pertain to you, in left-hand column

√ Check	Category	Score
	Age above 40	1
	Previous blood clot in legs (DVT) or Lungs (PE)	3
	Inability to walk more than a few steps	1
	Previous history of cancer	2
	Obesity (BMI >35=1 / BMI >55=2)	1
	Heart disease / Congested Heart Failure	3
	Varicose veins	1
	Limb trauma / injury	1
	Undergoing surgery (including proposed Bariatric Surgery)	1
	Hormone Replacement or Birth Control Pills	1
	History of Auto Immune Disease (Lupus, SLE, Rheumatoid Arthritis)	1
	Disease affecting the clotting of blood	2
SCORE:	**0-1 Factor = Low Risk 2-4 Factors = Moderate Risk >4 Factors = High Risk**	**TOTAL SCORE**

SLEEP SCREENING

Please check the following as they apply for you:

	QUESTIONS	YES	NO
Snoring?	Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	○	○
Tired?	Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving)?	○	○
Observed?	Has anyone observed you stop breathing or choking/gasping during your sleep?	○	○
Pressure?	Do you have or are being treated for high blood pressure?	○	○
Body Mass?	Is your body mass index more than 35 kg/m^2?	○	○
Age?	Is your age older than 50 years old?	○	○
Neck Size?	(Measured around adams apple) For male: is your shirt collar 17 inches/ 43 cm or larger? For female: is your shirt collar 16 inches/ 41 cm or larger?	○	○
Gender?	Is your gender male?	○	○
0-2 **Low Risk** 3-4 **Intermediate Risk** 5-8 **High Risk**		**TOTAL**		

Additional High Risk Indicators: "Yes" to 2-4 questions plus male gender or "Yes" to 2-4 questions plus BMI > 35 kg/m^2 or "Yes" to 2-4 questions plus neck circumference 17 inches/ 43 cm in males or 16 inches/ 41 cm in females.

PATIENT LABEL
OR
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DOB:__/_____/_____
MR #: _____

WEIGHT LOSS HISTORY

Please spend time completing this questionnaire in as complete detail as possible.

1. **Highest adult weight (non-pregnancy, since age 18): _____**
2. **Lowest adult weight (since age 18): _____**
3. **Please list any treatments for weight loss or eating in which you have participated for more than 1 month.**
   a. **Diets (Calorie counting, Weight Watchers, Jenny Craig, Atkins, Diabetic, Paleo, etc.)**
   b. **Diet Pills/Supplements (over-the-counter supplements such as Ali, Fat Burners, Dexatrim etc.)**
   c. **Prescription Medications (Phentermine, Wellbutrin, Topomax, Orlistat, etc.)**
   d. **Medically Supervised Programs (Liquid protein diets, Psychotherapy, Dietitian Counseling)**
   e. **Other (Weight Loss Surgery, Exercise Programs, Overeaters Anonymous, etc.)**

Please try to give as much specific information as possible

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

Name of Method_____ Date Tried:_____To _____

Weight Loss_____Weight Gained_____Results:

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Patient Health Information

PATIENT LABEL
OR

Patient Name:_____

DOB:_____/_____/_____

MR #: _____

EATING BEHAVIOR HISTORY

1) Have you ever had an episode of binge eating:
   a) Eating, in a 2-hour period, an amount of food that is definitely larger than most people eat in a similar period? ◯ Yes or ◯ No
   b) A lack of control over eating during a meal/snack (i.e. a feeling that you cannot stop eating or control what or how much you eat)? ◯ Yes or ◯ No
2) Please indicate on the scale below how characteristic the following symptoms are of your eating:

Symptom	Never	Rarely	Sometimes	Often	Always
Feeling that I can't stop eating or control how much I eat	◯	◯	◯	◯	◯
Eating more rapidly than usual	◯	◯	◯	◯	◯
Eating until I feel uncomfortably full	◯	◯	◯	◯	◯
Eating large amounts of food when not feeling physically hungry	◯	◯	◯	◯	◯
Eating alone because I am embarrassed by how much I am eating	◯	◯	◯	◯	◯
Feeling disgusted with myself, depressed, or very guilty after overeating	◯	◯	◯	◯	◯

3) Have you ever self-induced vomiting after eating in order to "get rid" of food eaten? _____
4) Have you ever used laxatives or diuretics to control your weight or "get rid" of food? _____
5) On average, how many meals do you eat each day? _____
6) On average, how many snacks do you eat each day? _____
7) Do you avoid certain foods: _____ If yes, what? _____
8) Please list all vitamins and supplements you take, even if not taken every day:

9) Please answer the following:

HAVE YOU EVER….	Yes – or - No	DO YOU CURRENTLY	HOW MUCH? WHAT TYPE?	HOW OFTEN?
Smoked cigarettes or cigars				
Vaped or used E-cigs				
Chewed Tobacco				
Drank energy drinks				
Used caffeine tablets				
Drank coffee				
Drank tea				
Drank sodas				
Drank alcohol				
Exercised for health or weight loss				

10) Do you wear dentures? _____
11) Do you have difficulty chewing or swallowing? _____
   a) If Yes, explain:

PATIENT LABEL
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