

All eight pages of this history form must be completed and returned prior to making an appointment

**Bariatric Patient
History Form**

Date _____ Ht. _____ Wt. _____
 Name _____ Age _____ Date of Birth _____ Sex _____
 Mailing Address _____ Home Phone _____
Street City County State Zip
 911/Street Address _____ E-Mail _____
Street City County State Zip
 Occupation _____ Employer _____ Work Phone _____
 Marital Status _____ Social Security Number _____ Referred by _____
 Spouse's Name _____ Spouse's Work Phone _____
 In case of emergency contact (other than Spouse) _____ Relation _____
 Address _____ Home Phone _____
Street City County State Zip
 Work Phone _____

Primary Insurance Comp. _____	Secondary Insurance Comp. _____
Address _____	Address _____
Policy Number _____ Group Number _____	Policy Number _____ Group Number _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Social Security Number _____	Subscriber's Social Security Number _____
Subscriber's Date of Birth _____	Subscriber's Date of Birth _____
Subscriber's Employer _____	Subscriber's Employer _____

I hereby authorize payment to North Florida Regional Medical Center of the surgical (and/or medical) benefits otherwise payable to me. I understand I am financially responsible to the hospital for charges not covered by my insurance policy.

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested to this claim and the attached bills. I certify that the information furnished by me in support of this claim is true and correct.

SIGNED: _____

MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request - I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

SIGNED: _____

Name and Address of your Primary Care Physician (Physician to whom you wish your records sent) _____

1. How long have you been overweight? _____ 2. Lowest Adult Weight? _____ 3. Highest Adult Weight? _____
4. Have you been to: Yes No Yes No Yes No
- | | | | | | | | | |
|-----------------|-----|-----|---------------|-----|-----|-------------|-----|-----|
| Weight Watchers | ___ | ___ | Nutri/Systems | ___ | ___ | Nutricenter | ___ | ___ |
| T.O.P.S. | ___ | ___ | Jenny Craig | ___ | ___ | Others | ___ | ___ |
5. What other diets have you tried? _____
6. What is the most weight you have lost on one diet? _____ Which diet? _____
7. Place an "X" next to any of the following diet pills you have taken:
 Fen/Phen Redux Adipex Fastin Pondimin Meridia Other _____
8. Have you been tried on shots? _____ If YES, What? _____
9. Physicians seen for weight loss: _____
10. Are you on a special diet now? _____ If YES, please describe. _____
11. Have you had any recent weight gain or weight loss? _____ If yes, how much _____
12. Do you have difficulty chewing / swallowing _____
13. Do you have a lack of appetite? _____
14. Would you describe your activity/exercise level as: none light moderate strenuous
15. Are other members of your family overweight? If YES:
- | | Relation | Approx. weight | Approx. height |
|-------|----------|----------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
16. What is your spouse's Height? _____ Weight? _____
17. What weight would you like to be? _____

Functional Assessment

1. Check any of the following that you have had:
- | | | |
|---|---|---|
| _____ Hypertension/High blood pressure | _____ Degenerative Joint Disease/
Osteoarthritis | _____ Infertility |
| _____ Diabetes/High blood sugar | _____ Sleep Apnea | _____ Venous stasis disease/
swelling of your legs |
| _____ Heart Disease | _____ Pulmonary Hypertension | _____ Bulimia |
| _____ Hypercholesterolemia/High Cholesterol | _____ Reflux Esophagitis | _____ Compulsive Disorder |
| _____ Hypertriglyceridemia/High Triglycerides | _____ Urinary stress incontinence | _____ Major Depression |
2. Do you require assistance for ambulation? If YES do you require a ___ cane ___ walker ___ wheelchair ___ other
3. Are you able to: Get in and out of bed? _____
 Climb stairs? _____
 Bend down to pick item off floor? _____
4. Are you able to: Take a Bath/Shower? _____
 Wash your hair? _____
5. When was your last: EKG _____ Chest X-Ray _____ Tetanus Shot / Booster _____

Operations / Previous Surgery

Procedure *Reason* *Year* *Hospital* *City and State*

Other Hospitalizations

Reason *Year* *Hospital* *City and State*

Other Medical Problems

Diagnosis *Age at Diagnosis* *Name and Address of Physician Treating*

Current Medications

Medication Name *Strength* *How Often* *Reason for Medication*

Have you EVER taken cortisone/steroids? When? _____ Why? _____

Allergies

Medication *Reaction* No Known Drug Allergies

Other allergies:(Including Food) _____

If you have or have had any of the following problems or diagnoses please mark and explain in the appropriate area.

<input type="checkbox"/> Anemia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Gallstones
Explain _____		

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Wear Glasses/Contacts
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Wear Dentures/False teeth
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Enlarged lymph glands	<input type="checkbox"/> Chronic fatigue/weakness
<input type="checkbox"/> Double vision	<input type="checkbox"/> Sinus trouble	
Explain _____		

<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Awake at night choking/short of breath
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Past history or currently have Tuberculosis
Explain _____		

<input type="checkbox"/> Heart Attack/M.I.	<input type="checkbox"/> Sleep on more than two pillows	<input type="checkbox"/> Pain in legs on walking
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Swelling in legs and ankles	<input type="checkbox"/> Stroke/Mini Stroke/TIA's
<input type="checkbox"/> Irregular Heart Rate	<input type="checkbox"/> History of heart murmur	<input type="checkbox"/> Fainting spell
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> History of rheumatic fever	<input type="checkbox"/> Blind spells
Explain _____		

<input type="checkbox"/> Chronic Nausea/Vomiting	<input type="checkbox"/> Vomit Blood	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diverticulosis/Diverticulitis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Colitis
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Use Laxatives
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Use Antacids
Explain _____		

<input type="checkbox"/> Kidney/Bladder infections	<input type="checkbox"/> Urinate more than twice at night	<input type="checkbox"/> History of Syphilis
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> History of kidney stone	<input type="checkbox"/> History of Gonorrhea
<input type="checkbox"/> Pain on urination	<input type="checkbox"/> History of kidney failure/insufficiency	<input type="checkbox"/> History of Genital Herpes
Explain _____		

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizure/Convulsion	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Gout	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Nervous breakdown
<input type="checkbox"/> Depression	<input type="checkbox"/> Numbness/Tingling in hands/feet	<input type="checkbox"/> Sexual Dysfunction/Difficulty
Explain _____		

At what age did your periods start: _____	Is it regular: _____	History of pain or heavy flow: _____
At what age did your periods stop: _____	Have you had any bleeding since: _____	Problems with urinary incontinence: _____
Last pelvic Exam: _____	Last PAP smear: _____	Have you had a hysterectomy: _____ Partial Complete
Pregnancies: _____	Miscarriages: _____	Abortions: _____
		Do you use: _____ IUD _____ Pill

Family History

<i>Relation</i>	<i>Age</i>	<i>State of Health</i>	<i>Obese?</i>	<i>Age at Death</i>	<i>Cause of Death</i>
Father:					
Mother:					
Brothers:					
Sisters:					
Spouse:					
Children:					

Any family members with a history of cancer, heart disease, high blood pressure, diabetes, or sickle cell anemia? If YES explain.

Personal Habits

1. Do you Smoke? YES NO ___ Cigarettes ___ Pipe ___ Cigars
2. If you smoke, how much do you smoke? _____ packs per day How long have you smoked? _____ years
3. If you don't smoke, have you smoked in the past? _____ When did you quit? _____
4. How much and how long did you smoke? _____ packs per day _____ years
5. Do you drink alcoholic beverages? YES NO If YES, how much? _____
6. Have you ever used illegal drugs? YES NO If YES, what? _____ when? _____

MOST INSURANCE COMPANIES WILL REQUIRE THE FOLLOWING INFORMATION. WE WOULD PREFER TO HAVE ACCESS TO IT SO THAT IT MAY BE SENT ALONG WITH YOUR INITIAL PRIOR APPROVAL LETTER, THEREFORE EXPEDITING APPROVAL FOR THE SURGERY.

WHAT DIETS HAVE YOU TRIED?

Diet: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

Diet: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

Diet: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

Diet: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

MEDICALLY SUPERVISED WEIGHT LOSS PROGRAMS:

Doctor's Name: _____
Address: _____

Phone number: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

Doctor's Name: _____
Address: _____

Phone number: _____
Dates: _____
Beginning Weight: _____
Ending Weight: _____
Total Weight Loss: _____

**North Florida Regional Medical Center
Center for Obesity Surgery & Treatment
Interdisciplinary Patient/Family Assessment Form**

Name: _____ Date: _____

1. Occupation? _____ Previous Occupation? _____

2. Number of years of school completed? _____

3. Do you have any of the following that may make it hard to learn?

Vision loss Hearing loss Physical limits Emotional problems Reading problems Language problems None

Describe? _____

4. How do you learn best? (check one): Demonstration Written Verbal

5. Primary Language? English Other _____

6. Do you have need for an interpreter? Yes No

One will be provided if needed.

Support Systems/Psychosocial Status

1. Marital status? Single Married Divorced Widowed

2. Number in household? _____

3. Primary emotional support person? (check one): Self Spouse Parent

Other _____

4. Any current major stresses? No Yes Please explain _____

5. Do you have a way to cope with stress? No Yes Please explain _____

6. Are you being abused or neglected? Yes No If YES, by whom? _____

Referral to: _____

Health Beliefs, Goals, & Attitudes / Cultural Factors / Discharge Planning

1. Any concerns regarding your health? No Yes Please explain _____

2. Any religious practices/restrictions? No Yes Please explain _____

Patient Signature _____