PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____

Zip: _____

Phone (Home/Cell): _____ Work Phone: _____

Reason for Consult (circle one): Surgical Non-Surgical Unsure

SOCIAL HISTORY

Work (Circle one): Unemployed Disabled Full-time Part-time Retired

Type of work: _____

Marital Status: Married Divorced Single Widowed Life partner

Current Stress level: (1 no stress to 10 highest stress ever had) _____

Smoke cigarettes: Yes No Number of packs/day: _____

Previous smoker: Yes No Quit date: _____

Electronic cigarettes/vaping: Yes No Number of times per day: _____

Cigars/pipe: Yes No Number of cigars/pipes per day: _____

Hookah: Yes No Quantity/times per day: _____

Chew tobacco: Yes No Quantity/times per day: _____

Drink alcohol: Yes / No Number of drinks per day: _____ Per week: _____ Per month: _____ Past use: _____

Past Treatment for addiction _____

Illicit Drugs: Yes / No Drug of choice: _____ Past use: _____

Past Treatment for addiction _____ Current use: _____

Cardiovascular	**Yes**
High blood pressure	_____
Congestive heart failure	_____
Heart stress test	_____
Heart attack	_____
Heart catheterization	_____
Stents placed in Heart	_____
Angina/chest pain	_____
Peripheral vascular disease	_____
Stroke	_____
Lower leg edema/swelling	_____
Blood clot in leg or lung	_____
Vena Cava heart filter	_____

Pulmonary	**Yes**
COPD	_____
Asthma	_____
Inhaler use	_____
Oxygen use at home	_____
Pulmonary hypertension	_____
Obstructive sleep apnea	_____
Use of CPAP/BIPAP at night	_____

Musculoskeletal	**Yes**
Back pain	_____
Joint pain	_____
Fibromyalgia	_____

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Place Patient Label Here

EPIC: ENC level to Patient Self Assessment - Scan
Description: Health History
Form M2252d (09/2020)

Gastrointestinal	**Yes**
Heartburn/reflux/GERD	_____
Heartburn medication	_____
Past anti-reflux surgery	_____
Barrett's Esophagitis	_____
Crohn's Disease or Colitis	_____
Abnormal liver test	_____

Reproductive	**Yes**
Polycystic Ovarian Syndrome	_____
Infertility	_____
Menstrual irregularities	_____

Metabolic	**Yes**
Diabetes, Type 1	_____
Diabetes, Type 2	_____
Fasting glucose > 99mg/dl	_____
Oral medication for Diabetes	_____
Insulin use	_____
Gestational Diabetes	_____
Kidney problems	_____
On dialysis	_____
High cholesterol/lipids	_____
Gout	_____
Thyroid	_____

Psychology	**Yes**
Anxiety	_____
Depression	_____
Bipolar	_____
Eating disorder	_____
Thoughts of suicide	_____
Suicide attempts	_____
Psychiatric counseling	_____
Hospitalized	_____

Past Surgical History (List any surgeries and dates)

_____

_____

_____

_____

Family History:

	Mother	**Father**	**Maternal grandparent**	**Paternal grandparent**	**Siblings**	**Other**
Obesity						
Heart disease						
Thyroid disease						
Stroke						
Cancer (type)						
Diabetes Mellitus						

PATIENT DIET HISTORY

WEIGHT HISTORY

Current height: _____

High school graduation weight: _____

Weight at marriage: _____

Highest adult weight: _____ Year of highest adult weight: _____

Lowest adult weight: _____ Year of lowest adult weight: _____

Personal/family history of weight loss surgery: Y / N, if yes who/what procedure: _____

_____

What do YOU attribute to your personal weight gain/struggles? _____

_____

Diet History	Time frame attempted	Weight lost/regained
Weight Watchers		
Low Carb (Atkins/Keto etc)		
Intermittent Fasting		
Physician/Dietitian managed		
Meal replacement drinks		
Nutri - System		
Jenny Craig		
Calorie Counting/portion reduction		
Portion reduction		
Other/Medications		
Physical Activity History		
None		
None but will start		
Activities of Daily Living		
Walking		
Running		
Treadmill		
Elliptical		
Biking		
Swimming		
Water Aerobics		

Place Patient Label Here

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What are your barriers to exercise?

_____

_____

CURRENT EATING PATTERNS

Do you regularly skip meals? _____

Do you regularly eat while doing other activities? _____

Do you snack between meals? If so, on what? _____

FOOD/BEVERAGE CHOICES

How many times a week do you eat out? _____

How many sweets/desserts do you eat a week? _____

Indicate your preference for these foods rated from 1 (like very much) to 4 (not at all):

Soda _____

High fat foods _____

Salty _____

Sweet _____

Specifically, what are your favorite foods? _____

_____

Please indicate how much you drink of each:

Water	_____	daily, weekly, monthly, yearly
Pop (Diet/Regular)	_____	daily, weekly, monthly, yearly
Caffeine	_____	daily, weekly, monthly, yearly
Juice	_____	daily, weekly, monthly, yearly
Alcohol	_____	daily, weekly, monthly, yearly

BEHAVIORS

Are you a fast eater? _____

Do you feel the need to clean your plate? _____

Would you say your portions are larger than you would need to be to get full? _____

Do you eat for reasons other than being hungry? _____

Have you ever been diagnosed with an eating disorder? _____

List any barriers, if any, that make it hard for you to eat healthy: _____

_____

MISCELLANEOUS:

Please list any food allergies or intolerances you have: _____

_____

Is there anything else you would like the bariatric team to know about your eating habits:

_____

_____