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Advanced Bariatric Centers, PLLC[®]

**MEDICAL HISTORY/ PHYSICAL EXAM
 PERSONAL WEIGHT LOSS HISTORY**

Date: _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Home phone _____ Work phone _____

DOB _____ Age _____ Social Security Number _____

Marital Status: M S W D Occupation _____

Race: _____ White _____ Black _____ Native American _____ Asian _____ Hispanic

Frame size _____ Small _____ Medium _____ Large _____ Extra Large

Height _____ Current Weight _____ if known / if not, estimate BMI _____

Referring physician _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Office phone _____ Fax number _____

How did you hear about our surgical and non-surgical options for obesity? _____

Chief Complaint: _____

History of Present Illness _____

Are you allergic to any medicine or foods? _____ NO _____ YES

Please list name and reaction to medication or food.

NAME	REACTION
1.	
2.	
3.	
4.	

Current medications you are taking, including vitamins, over the counter medications, herbal supplements, and intermittently used drugs.

NAME	Strength	Frequency	Purpose	When started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PAST MEDICAL HISTORY

(Please check and/or explain any of the items listed)

CARDIOVASCULAR

Heart Problems		
Chest Pains		
Racing, Heart/Skipping		
High Blood Pressure		
Chest Tightness		
Short of Breath		
SOB while Exercising		
High Cholesterol		
High Triglycerides		
Feel tired all the time		
Other		

DIABETES MELLITUS

NIDDM _____ IDDM _____

What year were you diagnosed as diabetic? _____

How long have you been taking oral agents? _____

How long have you been taking Insulin? _____

Does your Diabetes resolve with weight loss? _____

Pre-diabetic (abnormal glucose tolerance test) _____ NO _____ YES

Gestational Diabetic _____ NO _____ YES Age of diagnosis _____

Hypoglycemia _____

THYROID DISEASE

Hypothyroid		
Hyperthyroid		
Other		

GASTROINTESTINAL

Gallbladder disease		
Stomach ulcers		
Heartburn/reflux		
Irritable bowel syndrome		
Nausea/vomiting		
Constipation		
Diarrhea		
Abdominal pain		
Diverticulitis		

RESPIRATORY

Asthma		
Bronchitis		
Chronic cough		
Shortness of breath		
Blood clots-lungs		
Sleep apnea		
Snore		

Do you wake up gasping for breath? _____

Do you awaken with headaches? _____

Do you fall asleep frequently while reading? _____

Do you have heartburn or "reflux" while sleeping? _____

Do you have repeated difficulty falling asleep or staying asleep? _____

Do you often wake up with a dry mouth, sore throat or headache in the morning? _____

Do you CPAP or BiPAP? _____

Have you ever been to a sleep lab for treatment? _____

BLOOD/CIRCULATION

Stroke / Mini-stroke / TIA		
Bleeding problems		
Swelling/ Edema		
Anemia		
Blood clotting problems		
Hepatitis		
Previous blood transfusions		
Other		

Have you had blood clots in your legs? _____

Do you have varicose veins? _____

Do you have or have you had ulcers of the leg? _____

MUSCULOSKELETAL (Pain and/or swelling)

MILD

MODERATE

SEVERE

	MILD	MODERATE	SEVERE
Hip			
Knee			
Ankle			
Feet			
Back			
Neck			
Osteoarthritis			

Do you have any numbness or tingling of your extremities? _____

KIDNEY & BLADDER

Urinary tract infections		
Kidney stones		
Stress incontinence		
Other		

NEURO-PSYCHIATRIC

Depression		
Seizures		
Severe headaches		
Visual problems		
Dizziness		
Fatigue		
Anxiety		
Alcohol abuse		
Drug abuse		
Psychiatric disorder		

SKIN/INTEGUMENTARY

Eczema		
Psoriasis		
Rashes		
Acne		
Ulcers		
Other		

List any major illnesses (past and present).

Illness	Date	Treatment	Outcome
1.			
2.			
3.			
4.			
5.			

List any surgery.

Surgery	Date	Reason
1.		
2.		
3.		
4.		
5.		

Are you currently being treated for a medical condition? _____ NO _____ YES

If yes please specify: _____

Have you ever had surgery to aid in weight loss? _____ NO _____ YES

If yes please specify: _____

Date of previous gastric stapling
 or other weight procedure: _____

Have you used tobacco products in the past? _____NO _____YES
 If yes, how long? _____ Packs per day? _____
 Do you now use any tobacco products? _____NO _____YES
 If yes, how many cigarettes or packs per day? _____
 Do you drink alcohol? _____NO _____YES
 If yes what beverages and how many drinks per day? _____
 Do you consume caffeine (coffee, colas, chocolates, No-Doz[®])? _____NO _____YES
 If yes, in what form? _____
 How much per day? _____

FOR WOMEN

Have you had any problems conceiving? _____
 How many pregnancies have you had? _____
 How many children do you have? _____
 Do you have pain with your period? _____
 How regular is your period? _____

SOCIAL Describe your work and home life (family members, etc.): _____

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

	Mother	Father	Sibling	Aunt/Uncle	Grandparent
Obesity					
Diabetes					
Heart Disease					
Hypertension					
Cancer					
Arthritis					
Early Death					
Cause					

WEIGHT LOSS HISTORY

How long have you been overweight? _____

What kind of exercise programs have you tried? _____

Do you do any type of physical activity? _____ NO _____ YES

If yes, list below.

ACTIVITY (e.g. swimming, jogging, walking, etc.)	FREQUENCY (e.g. daily, weekly, monthly, etc.)

DIET HISTORY

Please identify the diet program(s) listed below that you have tried. Check below which programs apply to you and dates attended. Many insurance companies require documented evidence of more than 4 previous weight loss attempts so it is critical that you fill this out in detail.

	Approximate dates attended	Approximate length of time	Form of proof
Self Directed Programs			
Atkins Diet [®] (high pro/low carb)			
Slim Fast [®]			
Calorie counting			
Low fat diets			
Richard Simmons [®]			
Grapefruit Diet [®]			
Health Spa program			
Hypnosis			
Other			

Supervised Programs			
Weight Watchers [®]			
Overeaters Anonymous [®]			
Jenny Craig [®]			
Nutri-Systems [®]			
Physicians Wt. Loss [®]			
Diet pills from MD			
Supervised calorie counting diet by RD			
Other			
Other			

Medications			
Phen Fen [®]			
Redux [®]			
Meridia [®]			
Xenical [®]			
Orlistat [®]			
Acutrim [®]			
Dexatrim [®]			
Other			
Other			

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I hereby represent that I have completed this form as accurately and completely as is possible according to the information available to me at the time of its completion and that I understand the nature of the information sought. I further represent that I will furnish any incomplete data or correct any incorrect information as soon as it becomes known to me. I understand that this information will be used to determine whether weight loss surgery is appropriate for me and that incorrect or incomplete data may delay or even cancel my surgery.

Typed or Printed Patient Name _____

Signature _____

Date: _____

PHYSICAL EXAM

HT: _____ WT: _____ B/P: _____ (RT) _____ (LT)

Pulse: _____ RESP: _____ TEMP: _____ BMI: _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Neurological: _____

Skin: _____

Other: _____

DIAGNOSIS: _____

PLAN: _____

Physician _____ M.D. DATE _____