

Fresh Start Bariatrics Health History

Name _____ Date _____
 Height _____ Approximate Weight _____ Date of Birth _____

Past Medical History (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clots in legs or lungs: If yes, which? _____ | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Diabetes: If yes, Insulin? <input type="checkbox"/> |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Have you been seen by a heart, lung, or kidney specialist in the past 5 years? | |
| <input type="checkbox"/> Other _____ | If yes, which? _____ | When? _____ |
- Have you ever taken Phen Phen or Redux? Yes No When? _____

Social History

- Smoke? Yes No Packs per day _____ Ex-smoker, quit _____ years ago
 Alcohol? Yes No Occasional social drinker Recovering alcoholic
 Presently drink ____/day Drugs? Yes No Type and frequency _____

Do you have/have you had any of the following recently? (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Increased urination | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Burning w/urination | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Enl. Lymph nodes | <input type="checkbox"/> Reflux of gastric contents |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Extremity weakness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cough | <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Headache (esp. AM) | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin fold irritation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Snoring | <input type="checkbox"/> Abdominal pain | |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Use CPAP or BIPAP | <input type="checkbox"/> Use oxygen at home: If so, why? _____ | |
| <input type="checkbox"/> Do you need a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____ | | | |



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Past Surgeries:

Current Medications:

Allergies to Medication:

Are you allergic to latex? Yes No