

**Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

We will not share your information with any third party outside of our organization.

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact :** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Pharmacy Name and Phone Number:** \_\_\_\_\_

**1. Medical problems: (check all that apply)**

- High Blood Pressure       High cholesterol       Diabetes       COPD
- Congestive Heart Failure       Heart Attack       Kidney Disease       Urinary Incontinence
- Polycystic Ovaries       Back Pain       Joint Pain       Pseudotumor Cerebri
- Asthma       Atrial Fibrillation       Chronic Fatigue       Heartburn (Acid Reflux)
- Stomach Ulcers       Migraines       Stroke       Liver Disease
- Gout       Deep Vein Thrombosis       Pulmonary Embolus       Depression
- Anxiety       Sleep Apnea – CPAP/BiPaP settings \_\_\_\_\_
- Cancer (please specify type) \_\_\_\_\_
- Other \_\_\_\_\_

**2. Previous Surgeries/ procedures: (This includes all c-sections and hysterectomy, also include year of the procedure and if it was open or laparoscopic)**

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3. For women: Have you had a tubal ligation, Essure procedure or IUD implanted for pregnancy prevention? Yes/No

4. Are you medications up to date in our computer system? Yes / No

**5. Allergies – please include any drug allergies, and the type of reaction (for example, rash, or vomiting, or breathing difficulty) and level of severity (mild, moderate or severe):**

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**6. Have you been hospitalized or seen in the ER for any reason in the past year? Yes / No**  
 If Yes, please explain why (for example: chest pain, or abdominal pain, or car accident, etc):

Date:	What Hospital?	Reason for visit/admission?

**7. Have you been hospitalized or seen in the ER for any psychiatric reason in the past year? Yes / No**  
 If Yes, please explain why (for example: depression, panic attack, suicidal ideation, self harm, etc):

Date:	What Hospital?	Reason for visit/admission?

**8. Social history:**

- Do you smoke/ have you smoked in the past?  
 Yes / No # packs/day \_\_\_\_\_ # of years \_\_\_\_\_ Quit date: \_\_\_\_\_
- Do you use tobacco products (dip, chew, e-cigarette)?  
 Yes / No How often \_\_\_\_\_ # of years \_\_\_\_\_ Quit date: \_\_\_\_\_
- Do you drink alcohol? Yes / No Amount \_\_\_\_\_ How often \_\_\_\_\_
- Who do you live with? \_\_\_\_\_
- What is your occupation? \_\_\_\_\_
- Disabled: Yes / No If yes, what is the nature of your disability? \_\_\_\_\_
- Are you able to read: No Yes with difficulty Yes without difficulty

**9. Family History: (check all that apply)**

- Morbid Obesity     High Blood Pressure     Heart Disease     Lung Disease  
 Diabetes     Bleeding Problems     Cancer     Blood clot  
 Other: \_\_\_\_\_

**10. Activity History**

- What is the most demanding physical activity you participate in?  
 \_\_\_\_\_
- Can you walk for 1 block or 50 yards without stopping? Yes / No
- Can you do light house work, like dusting or doing dishes, without stopping? Yes / No
- Can you climb a flight of stairs without stopping? Yes / No
- What limits your activity (for example, joint or back pain, chest pain, or shortness of breath, or balance limitations, or vision limitations)? \_\_\_\_\_
- Do you use any of the following devices for assistance?  
 walker     cane     wheelchair     other \_\_\_\_\_
- Do you need assistance with any of the following activities?  
 eating     bathing     walking     dressing     other \_\_\_\_\_

**11. Weight Loss Program History Form: (PLEASE LIST ALL ATTEMPTS AT WEIGHT LOSS)**

Type of weight loss program (for example: Weight Watchers®, physician supervised diet, prescription diet pills, cutting calories etc):	Number of times tried	How long did you follow the diet	What year(s) did you try the diet	What were the results (long-term and short-term?)

**12. Are you currently experiencing any of the following problems on a frequent basis?**

<b>Constitutional:</b>			<b>GI:</b>		
Fevers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nausea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chills	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Reflux Symptoms (Heartburn)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent Diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>SLEEP:</b>			Frequent Constipation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Daytime sleepiness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Black, tarry stools	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Snoring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bloody stools	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stop breathing during sleep	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Abdominal pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Morning headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>GU:</b>		
<b>HEENT:</b>			Painful urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood in urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty eating or swallowing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Musculoskeletal:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Cardiovascular:</b>			Joint pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chest pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty breathing while lying down	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent muscular pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Neurologic:</b>		
Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower extremity swelling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Respiratory:</b>			Numbness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain on inspiration	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Wheezing	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

<b>Psychiatric:</b>			<b>Endocrine:</b>		
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent thirst	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Dermatologic:</b>			<b>Hematologic:</b>		
Rashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Easy bruising	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Non-healing wounds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding of gums	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Frequent nose bleeds	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**13. How did you hear about Tulane Bariatric Center?**

- Referred by a doctor    Doctor's Name \_\_\_\_\_ Doctor's Specialty \_\_\_\_\_
- Social media (please circle) Facebook Instagram
- Internet search
- Heard from a friend
- Other (Please describe) \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For office use only: STOP BANG Questionnaire**

- Snoring Yes / No
- Tired during the day Yes / No
- Observed apneas Yes / No
- Blood pressure (dx or being treated) Yes / No
- BMI (>35) Yes / No
- Age (> 50) Yes / No
- Neck circumference (>40 cm) Yes / No
- Gender (male) Yes / No

**Pictures have been taken and uploaded into EWC**