Health Care

Missouri Bariatric Services

Please bring this completed form to your initial visit

Name_____ **Today's Date**_____

Have you previously had Bariatric Surgery? ☐ No ☐ Yes

If yes: When_____ Where_____ Type_____

Reason for seeking a revision_____

please provide original bariatric surgery op report and recent testing with this questionnaire

Do you use tobacco products? (Cigarettes, chew, cigars, e-cig, pipes, etc.)

☐ **NEVER**

☐ **Past User:** What type? _____ When did you quit? _____

☐ **Current User:** How much? _____ For how long? _____

Do you have a history of alcohol / substance / drug abuse?

☐ **NEVER**

☐ **Past User:** What type? _____ When did you quit? _____

Did you attend treatment for drugs or alcohol? If so, when?_____

☐ **Current User:** What type? _____ How often? _____

Surgical History:

Type_____Reason_____Date_____

Type_____Reason_____Date_____

Type_____Reason_____Date_____

Family History: Did your mother (M) or father (F) have any of the following conditions? (please circle which one)

Heart Disease- **M / F** Diabetes- **M / F** Hypertension- **M / F** Cancer - Type_____ **M / F**

Stroke- **M / F** Obesity- **M / F** DVT (blood clot in legs)- **M / F** Pulmonary Embolism (blood clot in lung) **M / F**

Other: _____ **M / F**

Do you suffer from any of the following Psychiatric Disorders?

☐ Depression ☐ Schizophrenia ☐ Bipolar Disorder ☐ Suicide attempt, when_____

☐ Anorexia ☐ Bulimia ☐ Suicidal thoughts, when_____ Other: _____

Have you had or currently have any of the following?

Past	Now	Condition
		Reflux / Ulcers / Heartburn
		Pulmonary Embolism / DVT
		Diabetes
		Heart Disease
		Sleep Apnea with Sleep Study
		Daytime Sleepiness / Snoring
		Asthma / Emphysema / COPD
		Shortness of Breath / Exertional Dyspnea
		Stroke
		High Blood Pressure
		High Cholesterol / High Triglycerides

Past	Now	Condition
		Thyroid Disease
		Joint / Back / Foot Pain
		Arthritis / Osteoarthritis
		Swelling of Lower Extremities
		Kidney Disease
		Urinary Stress Incontinence
		Seizures
		Non-Alcoholic Fatty Liver
		Cancer
		Bowel Conditions
		Other:

What is your current exercise regimen?

☐ I am **unable** to exercise due to: _____

☐ I am **able** to exercise but I do not have a regular routine.

☐ I currently exercise by doing: _____

Minutes of activity: _____ Times per week: _____

Do you currently follow a special diet?

☐ No ☐ Yes Type: _____ How long? _____Pounds lost? _____

Please circle any of the following that you have previously utilized

Nutri-System	Medifast	Overeaters Anonymous	HCG Diet	Low Calorie Diet	Paleolithic diet	Mediterranean Diet	Subway Diet	Atkins Diet
Diabetic Diet	Weight Watchers	Self-imposed fasting	South Beach	Exercise Videos	Raw Food Diet	Vegan / Vegetarian Diet	Low Fat Diet	Slim-Fast
Phen-Fen	Topamax	Alli	Phentermine	Belviq	Ritalin	Amphetamine	Wellbutrin	Qsymia

Others?_____

Which meals do you eat each day? ☐ Breakfast ☐ Lunch ☐ Supper

Do you snack? ☐ No ☐ Yes When and what? _____

Do you drink plain water? ☐ No ☐ Yes How much? _____

Do you drink soda, juice, milk? ☐ No ☐ Yes What & How much? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes How many drinks per week? _____

Do you have any food allergies? ☐ No ☐ Yes What? _____

General	None	Weight Change, fevers/chills, fatigue, lost appetite, anxious
Eye	None	Vision change, glaucoma
Ear/Nose/Throat	None	Ringing in ears, change in voice, nose bleeds
Cardio-Vascular	None	Chest pain, heart attack, swelling of feet, dizziness/fainting, abnormal heartbeats, high blood pressure, blood clots
Respiratory	None	Shortness of breath, persistent cough, asthma, home oxygen use
Gastrointestinal	None	Nausea, vomiting, diarrhea, constipation, bloody stools, trouble swallowing, heartburn, abdominal bloating, ulcers
Musculoskeletal	None	Joint pain, joint swelling, joint stiffness, back pain, muscle aches, muscle weakness
Skin	None	Chronic skin condition, skin rash, unusual moles
Neurologic	None	Seizure, stroke, weakness, irritability, headaches
Endocrine	None	Diabetes, thyroid problems, hot/cold intolerance,
Blood	None	Anemia, easy bruising
Genitourinary	None	Urinary infections, pain when urinating, urinating frequently
Breasts	None	Breast pain
Allergies	None	Environmental allergies
Psychiatric	None	Depression, thoughts of suicide, anxiety

** NOTE: We provide education about nutrition and bariatric surgery in a group setting format due to the number of bariatric patients. Please know that all personal information is kept private during these classes. It will be your decision to share personal information or ask individual questions during the group sessions. **